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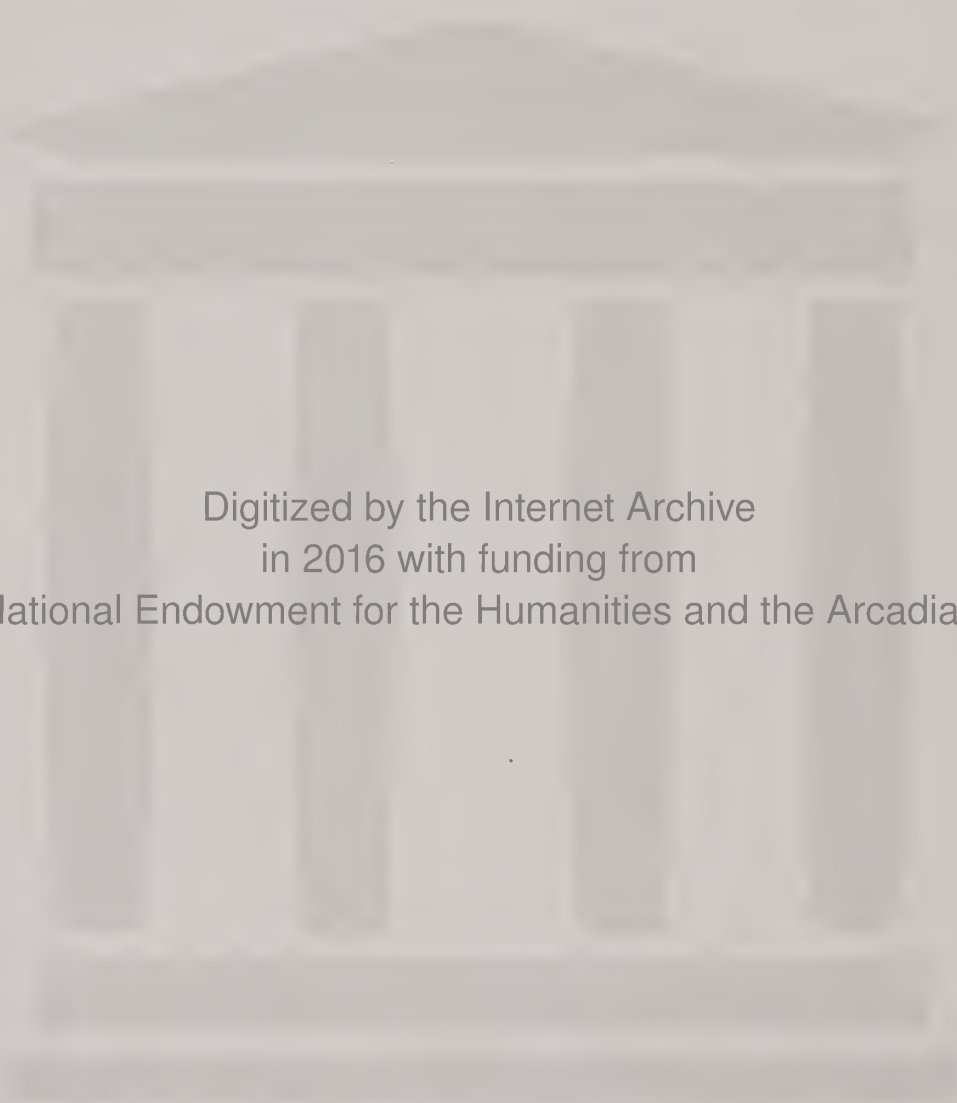


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Rapid Transformation of Cretins—Brown
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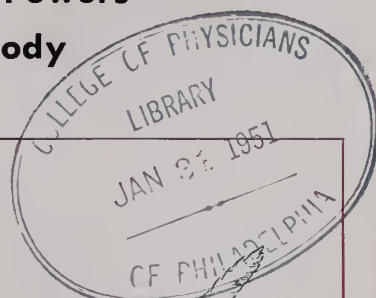
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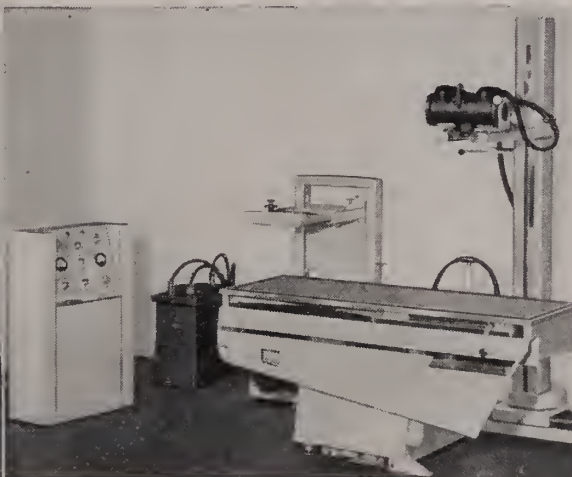
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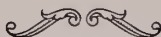
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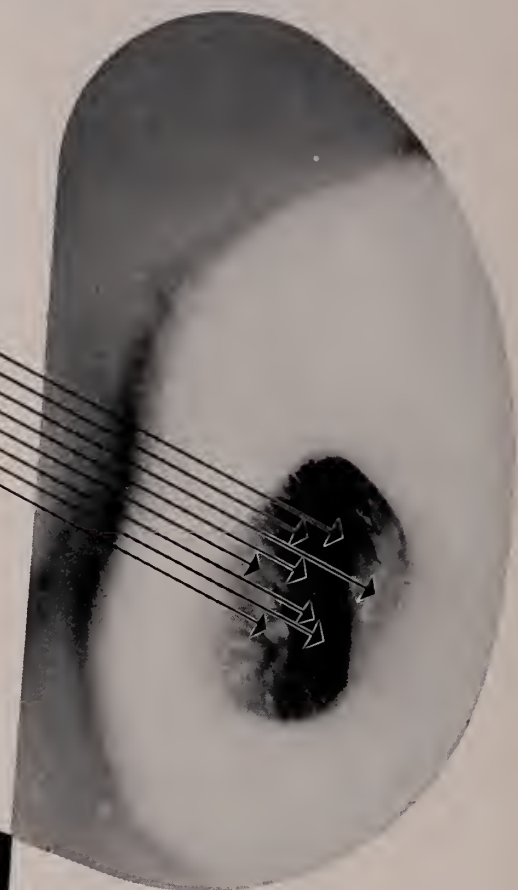
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**Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245; *N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592;
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

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*Pitt, C.K.: *The Art and Science of Artificial Infant Feeding*, J.M. Asso. Ala. 19:101 (Oct.) 1949.

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Most, H., and Van Assendelft, F.:
Ann. New York Acad. Sc. 53:427 (Sept. 15) 1950.



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Dowling, H. F.; Lepper, M. H.; Caldwell, E. R., and Spies, H. W.:
Ann. New York Acad. Sc. 63:433 (Sept. 15) 1950.

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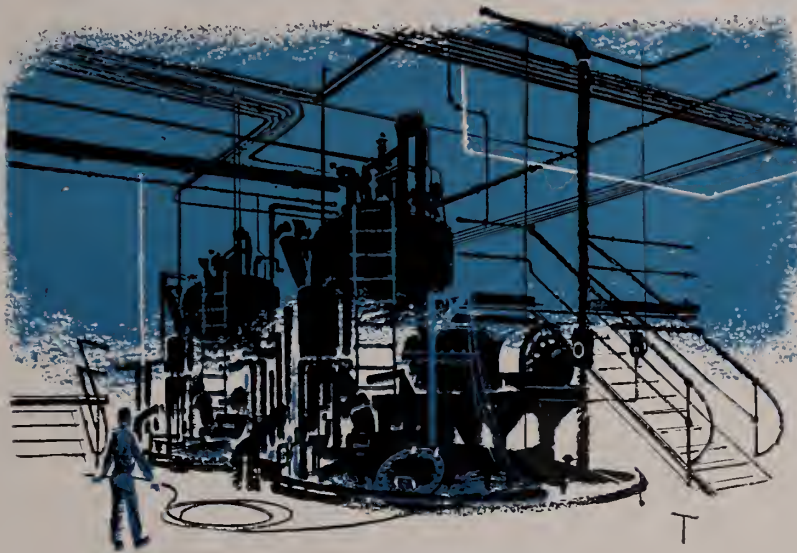
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NORTHWEST MEDICINE

VOL. 50, No. 1

JANUARY, 1951

\$3.00 Per Year

EDITORIALS

The Interim Cleveland Meeting

During recent years the activities of the American Medical Association have increased so enormously that it has been impossible to transact all of its business at its annual meeting. Consequently the interim meeting has been established which this year met at Cleveland December 5-8. It has been reported that the transactions at this meeting were conducted expeditiously to the complete satisfaction of those in attendance which are of vital

interest to all practicing physicians. It would be impossible to summarize the proceedings of its sessions which have been published in subsequent issues of *THE JOURNAL*. An official of one of our Northwestern state societies was present at all of the sessions and listened attentively to all proceedings. He selected the two following reports which he thought were of special importance and should be published at this time:

Financial Educational Aid to Medical Schools

A dramatic event, containing the element of pleasant surprise, was the A.M.A.'s action at its Cleveland interim session appropriating half a million dollars of National Educational Campaign funds to accredited medical schools, hard pressed financially. This was formal notice to the "little haberdasher on the Potomac" that the medical profession does not want and will avoid accepting, if at all possible, federal aid to our medical schools with the accompanying dictation that always is attached to such aid. The A.M.A.'s appropriation was made "without strings for use by the medical institutions in their basic training of future physicians." Chairman of the A.M.A. Board of Trustees, Louis H. Bauer, did say that it was presumed the schools would not use the funds for construction purposes.

The significant thing about the A.M.A. action is not the appropriation itself, \$500,000 being insignificant when divided among 79 schools. But the sum is expected to, and no doubt will, be a magnet to funds from agencies such as other professions, industries, businesses, labor groups and private donors. Doctors themselves clamored for information as to where to send their checks, following the announcement, and thus it is foreseen the original amount will be greatly enlarged by medicine itself. The doctors were told to await the formation of a nonprofit organization to accept and allocate to the schools expected donations. The A.M.A. also urges

its members to take the lead in obtaining other contributions.

There is every possibility the idea will assume the proportions of a snowball in its course downhill, finally bursting in such a shower of financial aid to our medical schools that the federal government never again will attempt to get its long and filthy clutches on the medical profession through the back door of its medical institutions, in the hideous form of "Benevolent Financial Aid." In other words, the A.M.A. endowment is expected to be a nucleus for a nation-wide fund to be raised from nonpolitical sources.

It also is one answer among many to the question raised by some of the A.M.A. members, "What becomes of the \$25 dues I pay every year to the A.M.A.?" The A.M.A. donation is in addition, it might be pointed out at this time, to the more than a quarter-million the A.M.A. spends yearly, through its Council on Medical Education and Hospitals, for the advancement of medical education.

Dr. Bauer explained that American Medicine feels strongly that it should not seek federal aid until all other means of financing have been exhausted. This is the proper attitude and every physician should subscribe to it both morally and financially. The profession also should be forever thankful to A.M.A. President Elmer L. Henderson, whose idea it was that his organization start this "financial snowball" rolling.

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Public Relations Program

The Grievance Committee as a public relations factor received more support and credit by speakers in Cleveland than any other plank of any program. It was praised as a threat to the unethical practitioner, thus keeping him in line, and was given credit for greatly reducing the number of malpractice suits. Through this medium, speakers said, the public is given a better understanding of the practice of medicine and the doctor finds out what the patient expects of him. More and more county and state societies were reported creating grievance committees and finding them successful wherever a sincere attempt is made in their operation.

Rated next to the grievance committee in importance as a public relations asset is providing a doctor for the patient who needs one, commonly known as "Emergency Service." This was said to be of the greatest immediate importance in physician-relationship with the public, because any personal physical catastrophe attached with inability to obtain services of a physician makes the headlines and thus causes public condemnation of the whole profession.

Overcharging the patient is another complaint, mentioned frequently by Cleveland speakers, which they said must be quickly squelched for effective public relations. This piece of poor public relations seldom reaches the newspapers, but gets the same negative result for the profession by the devastating oral prairie fire it arouses. County and state societies reporting programs embracing setups to settle grievances, to provide doctors for patients when they need them, and to curb overcharging, claimed the best success in improving relations with the public.

Naturally, all these approaches are by way of the back door and will not be more than partially successful. Best answer to public relations is education of the doctor to the absolute necessity of good personal relations with the patient in the office, in the home and in the hospital. Human nature being what it is, even among doctors, it is a little hopeless to expect such perfect relationship in the near future, so the necessity for a program embracing at least the aforementioned planks will continue to be "front-burner" priority for every medical society for a long time to come.

News One Hundred Five Years Old

A half million dollars has been appropriated by the American Medical Association for the aid of medical schools. This is the most significant report coming from the interim session at Cleveland and one of the most constructive moves made by the A.M.A. for years. It gives real emphasis to the slogan that the voluntary way is the American way. It cuts to the very center of the argument of those who feel that a paternalistic government should be responsible for everything, including the education of future practitioners of medicine.

The announcement that the A.M.A. was vitally interested in medical education was published as exciting news in papers across the country. Actually it was news just one hundred five years old. Indeed, the very idea of a national organization of physicians grew out of the desire to improve medical education. The year 1845 saw a resolution introduced into the annual meeting of the New York State Medical Society which resulted in the formation of the American Medical Association. The only reason for the suggestion was the improvement of medical education. The resolution, introduced by Nathan Smith Davis of Binghampton, is as follows:

Whereas: It is believed that a national convention

would be conducive to the elevation of the standards of medical education in the United States; and

Whereas: There is no mode of accomplishing so desirable an object without concert of action on the part of the medical colleges, societies and institutions of all the states; therefore be it

Resolved: That the New York State Medical Society earnestly recommends a national convention of delegates from the medical societies and colleges in the whole Union to convene in the city of New York on the first Tuesday in May in the year 1846 for the purpose of adopting some concerted action on the subject set forth in the foregoing preamble.

The 1846 meeting was held in New York and it passed another resolution drawn up by Dr. Davis to the effect that a national medical association should be formed, that standards for medical education should be uniform and that young men should acquire a suitable preliminary education before entering the study of medicine. The national association was formed and held its first meeting as the American Medical Association in Philadelphia in May, 1847, an organization established for the primary purpose of elevating the standards of medical education in the United States.

Early history of the A.M.A. is marked by references to medical education. A resolution setting up certain requirements for preliminary education was passed at the first meeting in Philadelphia. A year later the committee on medical education re-

ported that there had already been important changes made in curricula of several schools as a result of the first meeting. In 1849 one famous medical school presented vigorous argument against lengthening its course of instruction as desired by the committee. In 1884 Austin Flint, president, concluded his address to the annual session with these words: "The practical question is, 'What can the Association do to promote more and more the elevation of the standard of medical education?'" *The Journal of the American Medical Association* began a campaign against diploma mills by publishing a list of fraudulent medical institutions in its issue of March 31, 1894.

Finally, in 1904, the Council on Medical Education and Hospitals was organized. Thus was set in motion the most powerful influence ever brought to bear on medical education. Diploma mills were

put out of business, weak schools were merged to form strong institutions and standards were steadily raised. Today we accept the fact that medical education in the United States is the best in the world. No one who reads the history of its growth can doubt the part played by the organization suggested by Dr. Davis in 1845.

Thus, the act announced at Cleveland is not new. The idea may have taken a new form. Physicians individually and collectively throughout the land will add to the fund. Others, also, as they aided in the National Education Campaign, will make voluntary contributions. But the American Medical Association is doing nothing new at all. In putting its dollars on the line to help maintain the quality of medical education in the United States it is merely following the course which Nathan Smith Davis charted for it one hundred five years ago.

Correct Age of Journal

On the first cover page of this Journal is stated Volume 50, Number 1, which would indicate that it is entering the fiftieth year of its publication. This is an error, since this is the beginning of its forty-ninth year. This is due to an incident in the Journal's history which occurred in 1909. In the fall of 1908 a group of prominent Portland physicians conceived the idea of establishing closer relationships between practitioners in Oregon, Washington and Idaho. Such associations were natural for several reasons.

Originally these three states comprised Oregon Territory. They have many common natural resources with similar agricultural, mineral, fishing and other characteristics. Also, they were equally out of touch with medical centers on account of long distances of transportation. In January, 1909, representatives of the three state medical societies met in Portland and organized the Tri-state Medical Society. It was incorporated with provision that it should hold a united meeting every three years, rotating among the three state associations,

one acting as host while the other two guest associations would suspend their annual meetings. It adopted NORTHWEST MEDICINE as its official medical journal, its ownership and management being transferred to the Tri-state Society.

The first tri-state meeting was held in July of that year in Seattle, where the Alaska-Yukon-Pacific Exposition held its notable meeting which was largely attended and the medical meeting attracted the greatest number of physicians who had ever been present at a medical meeting in this part of the country. This series continued for two rounds and then expired from inanition.

NORTHWEST MEDICINE was publishing volume 7, one column to a page of 7 x 4 inches. Beginning with the July issue, the Journal was enlarged to its present size and a new volume was established, thus making two for that year. Accordingly, the half-century existence of the Journal will not occur until 1952, at which time a suitable anniversary will probably be observed.

**The Ninetieth Birthday Anniversary
of Our Editor,
DR. CLARENCE A. SMITH
and the
Fiftieth Anniversary of
Northwest Medicine**

will be observed in our February issue. We of the staff know that Dr. Smith will be glad to receive letters, telegrams or messages

from any who desire to recognize the occasion.

Dr. Smith will be 90 years of age on January 24th. Messages should reach him on or before that date. His address is 309 Douglas Building, Seattle, Wash.

NORTHWEST MEDICINE

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ORIGINAL ARTICLES

Rapid Transformation of Cretins with Large Doses of Thyroid

EDWARD E. BROWN, M.D.

ASHLAND, ORE.

THE PHYSICIAN has within his grasp a potent agent for treating the cretin, namely, desiccated thyroid substance. Yet, only too often in his conservatism he administers insufficient amounts of this specific medicine. The pathetic spectacle of cretinism recorded here is the result of prolonged "micro-dosage" (figs. 1, 2). With large dosage of thyroid the cretin can be transformed in a short time to an alert, vivacious child (figs. 3, 4, 5, 7, 8).

In treating cretinism what is an insufficient dose of thyroid and why is it being prescribed? A dose of one grain or less daily is insufficient. Many physicians are apparently fearful of giving more than this amount. Parents, too, are frightened of "toxic" symptoms often caused by more than one grain daily and, as Ronald¹ points out, the child is then left without treatment for a long time.

Admonitions regarding the use of large doses include: "It is physiologically unsound . . . nothing to be gained and it may actually be dangerous."² Abt³ believes "it is far from desirable to give a dose sufficient to produce the full physiologic effect" and continued overdosage may cause thyrotoxicosis. Bruch⁴ cautions that disorders of behavior arise because of overdosage of thyroid.

Apparently these admonitions result in ultra-conservatism on the part of many practitioners. The history of our patients reveals that not more than .5 gr. of thyroid was prescribed. The parents became dissatisfied with lack of progress and consulted many physicians.

The following case reports and photographs illustrate the fallacy of a dosage of .5 gr. of thyroid daily. They also illustrate the remarkable transformation in several weeks when 3 or 4 gr. daily are used.

CASE REPORTS

Case 1. J. L., male, aged 21 months, was dull, apathetic and showed a protruding, large tongue and edematous, wrinkled folds in his forehead (fig. 1).

1. Ronald, A.: Hypothyroidism in Childhood. *Indian J. Pediat.*, 6:223-230, Oct., 1939.
2. Hurxthal, L. M.: Treatment of Myxedema and Cretinism. *Clinics*, 5:763-774, Dec., 1946.
3. Abt, I. A.: Endocrines in Relation to Growth in Childhood. *Illinois M. J.*, 77:137-141, Feb., 1940.
4. Bruch, H. and McCune, D. J.: Mental Development of Congenitally Hypothyroid Children; Its Relationship to Physical Development and Adequacy of Treatment. *Am. J. Dis. Child.*, 67:205-224, March, 1944.

Past history: Birth weight, 6 lb., 14 oz.; always a poor feeder, listless and weak, constipated since age two months. He had his first tooth at 19 months and held his head up at 20 months. Cretinism was apparently suspected at 3 months when he was placed on thyroid, the dose being .5 gr. daily until I first saw him at 21 months.

Physical examination: Temperature 97° F., rectal. Length 28.5 inches, weight 21 lbs., 2 oz. Anterior fontanelle, 3 fingers. Cradle cap on head, eczema on back. Large tongue, mouth open. Two lower incisors present and one upper incisor emerging. Testicles normal in size (large pea). Musculature hypotonic, soft abdominal distention.

Laboratory findings: Red blood cells 3,750,000, hemoglobin 70 per cent. Roentgenogram of wrists showed no carpal bones (fig. 2).

Therapy: Thyroid* was increased from .5 gr. to 3 gr. in one daily dose. Constipation disappeared, appetite improved greatly, he became animated and perspired for the first time. He slept fitfully. At the end of the week's treatment his weight was 20 lb., a loss of 1 lb.

During the second week dosage of thyroid was increased from 3 to 6 gr. but was reduced after three days to 3 gr. because of diarrhea, restlessness, fitful sleep and spells of rapid breathing. Pulse at end of second week was 144. Appetite was good. Weight 20 lb., 8 oz. (fig 3).

During the third week 3 gr. of thyroid were continued. Rapid breathing occurred in spells and perspiration was moderate. Appetite and bowel movements were normal. Eczema disappeared. Heart rate continued rapid, 144. Sleep fitful. Mouth was now closed and tongue was no longer large and edematous. Anterior fontanelle was now 2.5 fingers. Rectal temperature, 100° F. Weight 20 lb., 10 oz. (fig 4).

During the fourth week 3 gr. of thyroid were given for four days and then reduced to 2 gr. because of continued rapid pulse (144) and fitful sleep. On 2 gr. daily the heart rate slowed to 120 and the child slept soundly. He was alert, interested in surroundings and had a normal facies (fig. 5). Anterior fontanelle was now 1.5 fingers. Second upper incisor appeared, four teeth in all. Rectal temperature was 99.4° F. Weight was 21 lb. and length 29.25 inches.

Baby returned to his home in another state but letter from parents stated that after another four weeks on 2 gr. he weighed 22 lb. and had eight teeth. He laughed frequently. One month later, three months after starting large dosage, he was

*Thyroid used in both cases was that of Eli Lilly & Co.



Fig. 1. Male cretin, aged 21 months, barely able to hold up head. Note large tongue and senile appearance. Thyroid, .5 grain daily, had been taken since age three months.

Fig. 2. Absence of carpal bones; two should be present.

Fig. 3. After one week's treatment with 3 grains thyroid daily.



Fig. 4. After two weeks' treatment.

Fig. 5. After four weeks' treatment.

making an effort to stand and two months after this he was reported to be walking.

Case 2. G. J., girl, aged 8.5 years, was dull, slow in action and expressed no interest in her surroundings (fig. 6).

Past history: Birth weight 7.5 lb.; at one year 7.5 lb. Sat at age one and a half years, walked at age four years. Because of slow development she was taken at age of two to a hospital connected with a state medical school, where a diagnosis of cretinism was made and thyroid, $\frac{1}{4}$ gr., was prescribed to be given twice daily. Subsequently, when no noticeable improvement was seen, the patient was taken to several physicians. The dose of thyroid was reduced to $\frac{1}{4}$ gr. once daily until she was eight years old. At this time a physician advised discontinuance of thyroid. For six months prior to my examination (fig. 6) she received no thyroid therapy.

Physical examination: Nov. 25, 1947, temperature 97.2° F., rectal. Pulse 60. Height $37\frac{1}{2}$ inches. Weight 39 lb. Dry hair, large tongue, small hypoplastic separated teeth and pot belly.

Laboratory findings: Red blood cells, 3,490,000; hemoglobin, 62 per cent, 10.5 Gm. Roentgenogram of wrists, two small carpal bones (fig. 9). At this age there are normally seven carpal bones.

Therapy: Nov. 25, 1947, desiccated thyroid sub-

stance, 3 gr. in one daily dose. Two weeks later she lost 2 lb. and increased $\frac{1}{2}$ inch in height. Pulse was 96, temperature 99° F., rectal. She perspired freely, constipation disappeared and she became more alert.

Jan. 20, 1948, thyroid 4 gr. daily. March 1, height 39.5 inches, weight 36.5 lb. (fig 7). June 25, height 41 inches, weight 38 lb. Aug. 6, height $41\frac{1}{4}$ inches, weight 44 lb. Fluoroscope revealed five carpal bones.

Feb. 12, 1949, height $44\frac{1}{4}$ inches, weight 50.5 lb. May 27, height 45.5 inches, weight 52 lb. At this time pulse increased to 108, she became nervous and jerked her shoulders. Thyroid was omitted for two days and then reduced from 4 to 2 gr. daily.

July 7, height 46 inches, weight 55 lb. Thyroid increased to 3 gr. Aug. 25, height 46 inches, weight 55 lb., pulse 96, nervous. Thyroid reduced to 2 gr. Sept. 21, height 46 inches, weight 56 lb., pulse 96. Dec. 9, height 47 inches, weight 58 lb., pulse 96 (fig. 8).

March 15, 1950, height 48 inches, weight 60.5 lb., pulse 90, temperature 98.4° F. Thyroid increased to 3 gr. to present, July, 1950, at which time roentgenogram reveals seven carpal bones (fig. 9).

She now uses sentences but speaks indistinctly. She is able to copy a circle and square. She is bashful but plays well with other children.



Fig. 6. Cretin, aged $8\frac{1}{2}$ years, beside normal boy, aged $3\frac{1}{2}$. Height of cretin $37\frac{1}{2}$ inches; boy $36\frac{1}{2}$ inches.

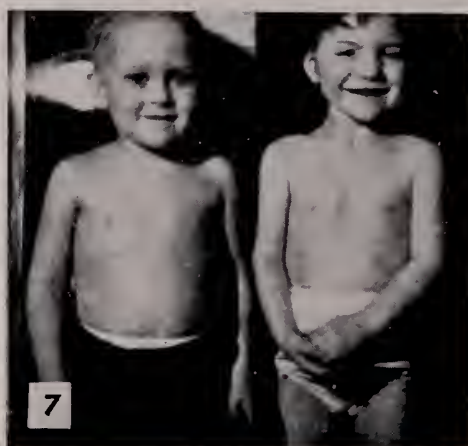


Fig. 7. After three months on large doses of thyroid. Note alertness; also loss of weight.

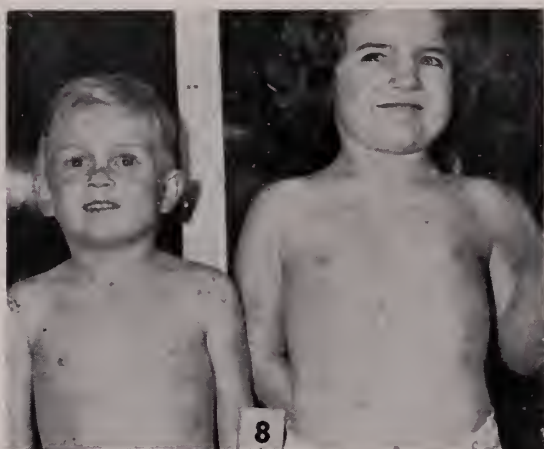


Fig. 8. After two years. Height of cretin 47 inches; boy 42 $\frac{3}{4}$ inches. Cretin gained $9\frac{1}{2}$ inches in height and 19 pounds in weight.



Fig. 9. Roentgenogram of wrist at ages $8\frac{1}{2}$ (left) and 11 (right).

What is the proper dose of thyroid? In general the cretin should be given the largest dose he can safely tolerate. A child only slightly deficient in thyroid secretion may require but one-half grain daily.

On the other hand, a child whose thyroid gland is absent or completely functionless, a true cretin, may require up to three grains or more daily, at least until dangerous symptoms develop.

To determine a proper dose of thyroid, a distinction must be made between *toxic* and *dangerous* symptoms. Some toxic symptoms may be expected in treating cretinism with one grain or more daily. These symptoms must be tolerated for a time in order to compensate for that period when growth and development lagged. Rapid pulse, mildly elevated temperature, initial loss of weight, increased nervousness and frequent bowel movements are tolerable symptoms of toxicity which probably indicate a slight degree of hyperthyroidism and may be disregarded.

On the other hand, dangerous symptoms are

extreme restlessness, twitching, diarrhea or vomiting, continued loss of weight, very rapid pulse rate, high fever and syncope. In our patients these did not develop. There was restlessness and frequent stools but no diarrhea except on one occasion when six grains of thyroid were given. In the younger cretin, there were spells of rapid breathing when three to six grains of thyroid were taken, but when the dosage was reduced to two grains, he slept well and the pulse dropped from 144 to 120.

Bronstein and Reals⁵ consider that adequate dosage may be determined by physical, osseous and mental growth and by the avoidance of severe toxic symptoms. They prescribe larger doses than advocated by Means.⁶ On the basis of experience in a series of fifty patients with hypothyroidism whom they treated during ten years, Bronstein and Reals feel that a rigid table of dosage is impracticable but the average doses are as follows:

5. Bronstein, I. P. and Reals, W. H.: Inadequately Treated Cretin. *Arch. Surg.*, 42:1048-1053, June, 1941.

6. Means, J. H.: *Thyroid and Its Diseases*. J. B. Lippincott Company, Philadelphia, 1937.

Age	Daily dose of thyroid
6 months to 1½ years.....	½ to 1½ gr. (0.03 to 0.09 Gm.)
1½ years to 8 years.....	1 to 3 gr. (0.06 to 0.18 Gm.)
8 years to adolescence.....	1½ to 3 gr. (0.09 to 0.18 Gm.)

This dosage approaches the ideal but may have to be increased for maximal results. Bronstein and Reals state: "Not infrequently it has been necessary for us to employ much larger doses than those mentioned in order to obtain optimal responses. . . . It is better to push the dose and watch for reactions than to underdose for years, as histories of cretins so frequently reveal."

Why are large doses of thyroid necessary? The prognosis for normal mental and physical development is extremely poor, if large doses are not given. There occurs a delay in the development of the brain⁷ and histologic changes in the brain cells.⁸ Impressed by the frequency of mental retardation, Aldrich⁹ advocated administration of the largest tolerable dose of thyroid.

Large doses of thyroid are relatively safe in children. Hurxthal¹⁰ states: "Desiccated thyroid may be given with little danger in childhood. The vascular system is more elastic and it is unlikely that any serious damage can ensue."

Can one make up for lost growth by pushing the dose of thyroid? Opinions differ. Hurxthal¹¹ does not believe that the delay in growth caused by thyroid deficiency before treatment is started can be recovered. He states: "The ultimate height of a cretin on adequate therapy will be the height which he would have attained under normal conditions, minus the amount of growth retardation which took place during the period of thyroid deficiency."

On the other hand, Bruch and McCune note after treatment that the height of a child "increased at about twice the normal rate during the first year of treatment, and then at a rate which was slower but still in excess of the normal increment." Likewise, Holt and Howland¹² observed that in a child with infantile myxedema aged three and a half years "the height which had been stationary for some months increased nearly four inches in six months as the result of thyroid medication."

In my patients physical and mental development beyond the expected range was obtained in a short

time. In the twenty-one-month-old cretin, after only one month's treatment with three grains of desiccated thyroid substance daily, the rapidity of physical growth was evidenced by a gain in length of three-quarters of an inch (double the normal growth), and closure of the anterior fontanelle from three to one and a half fingers.

In the eight-year-old cretin rapid physical development was revealed by almost doubling of the normal gain in height and weight after two years of treatment. In two and a half years the skeletal age advanced from that of a two-year-old to that of a seven-year-old child, double the normal gain. Her mental age at the onset of treatment was difficult to assess because of her unresponsiveness and a comprehension apparently not equal to a normal two-year-old child. Speechless at age eight, after two years of treatment she made herself intelligible in sentences of five or six words and had some aptitudes of a four-year-old child.**

DISCUSSION

The conscientious physician is on the horns of a dilemma in treating the cretin. He may be conservative and ask himself "shall I play safe with one-half or one grain thyroid and probably obtain mediocre results?" On the other hand, he may ask, "shall I push the dose as long as I can observe the child at frequent intervals and thus give him a chance to attain normality?"

It seems to me that, if the parents are cooperative, the physician must assume the responsibility of full dosage, with a frank explanation both of the dangers involved and the poor prognosis if maximal dosage is not given.

CONCLUSIONS

Two cretins, treated by many physicians with one-quarter and one-half grain desiccated thyroid substance, made little mental and physical progress over a period of many months. When increased to a dose varying between two and four grains daily, gratifying transformations mentally and physically were noted in a short time.

Proof is presented that large doses of thyroid enable the cretin to regain some of his lost growth, heretofore a controversial point.

Toxic symptoms, which should be differentiated from dangerous symptoms, may be produced by an optimal dose of thyroid. The physician must take the responsibility of prescribing this large optimal dose, if he can see the child at frequent intervals. To give less is to deprive the cretin of his only chance for full mental and physical development.

7. Wilkins, L. and Fleischmann, W.: Diagnosis of Hypothyroidism in Childhood. J. A. M. A., 116:2459-2465, May 31, 1941.

8. Lotmar, F.: Histopathologische Befunde in Gehirnen von kongenitalem Myxodem (Thyreoplasie), Ztschr. f. d. ges. Neurol. u. Psychiat., 119:491, 1929.

9. Aldrich, C. A. and Munns, G. F.: Growth and Development: Endocrine Glands and Growth. J. Pediat., 10:398-412, March, 1937.

10. Hurxthal, L. M.: Cretinism. Med. Cl. North America, 33:122-139, Jan., 1948.

11. Hurxthal, L. M. and Musulin, N.: Cretinism. Am. J. Med., 1:56-82, July, 1946.

12. Holt, L. E. and Howland, J.: Diseases of Infancy and Childhood, p. 859. D. Appleton-Century Co., New York, ed. 8, 1925.

**Mental tests given by Prof. L. E. Messenger, Southern Oregon College of Education.

Medical Care Problems in a Group of Patients With Chest Pathology*

LEE POWERS, M.D.**

SEATTLE, WASH.

A MASS chest roentgen survey of adults (15 years of age and over) was conducted in Tacoma and Pierce County, Washington, during February, 1949, by the Tacoma-Pierce County Health Department through the assistance of United States Public Health Service and Pierce County Tuberculosis League. Pierce County Medical Society, recognizing the opportunity in the survey of investigating medical care problems of a group of patients with demonstrable pathology in the chest, requested the Department of Public Health and Preventive Medicine of University of Washington School of Medicine to conduct such a study. The medical society provided funds for the additional personnel necessary to complete the study.

A schedule of sixty questions was prepared to elicit and check answers necessary for the study. Before the final schedule was accepted a trial run was made in a public clinic and modifications were made from the experience of this trial run. Two medical social workers, two public health nurses and a supervising public health nurse, with many years of experience in interviewing patients in a venereal disease clinic, were trained in use of the schedule. The four interviewers were supervised throughout the study by the supervising public health nurse. Frequent meetings of the interviewers were held during the first few days of the interviewing periods to be certain the technics and interpretations were as uniform as possible.

Individuals, whose 70 mm. films revealed a suspicious density, received a 14 x 17 film. These were reviewed by a board of roentgenologists and internists. Patients, whose films indicated need of treatment or further investigation, were recalled to the clinic and the findings were explained. Patients were interviewed for this study at the time they were recalled to the clinic for the interpretation of the 14 x 17 film. All questions in the schedule, which involved diagnosis and evaluation of symptoms, were completed by the two clinic physicians who explained findings in the film to the patients. The patients were then referred to their private physicians or a clinic. Each schedule was checked for clarity and completeness of the answers by the supervising nurse immediately upon completion.

The final results were then punched on I.B.M. cards and tabulated.

The Pierce County Medical Society was particularly interested in the answers to the following questions:

1. What percentage of the persons with definite chest findings had subjective symptoms?
2. What percentage of the above individuals sought medical care or advice because of the symptoms experienced?
3. What were the most frequent reasons given by patients for not seeking medical care when definite subjective symptoms were present?
4. What were the most frequent reasons given by patients, who sought medical care, for not following the recommendations made by their physicians?

The report which follows deals only with the above four questions. Additional information obtained in the study will be reported at a later date.

CASES ROENTGENIZED AND NUMBER INTERVIEWED

The estimated population of Pierce County and Tacoma, 15 years of age and over, for the year 1948 was 157,720. Satisfactory miniature films (70 mm.) were obtained on 72,703 or 46 per cent of the population 15 years of age and over. Approximately 2 per cent (1,462) of the miniature films were screened as needing a larger film (Table I).

Table I

Tacoma & Pierce County, Washington X-ray Survey February 1949	
Total Estimated Population 15 Years of Age & Over (1948)*	157,720
No. of Miniature Films Taken (70 m.m.)	72,703
% of Population Over 15 Years Surveyed with 70 m.m. Film	46%
No. of 70 m.m. Films Interpreted as Having Abnormal Densities	1,462
% of Abnormal 70 m.m. Films of Total Surveyed	2%

*State Dept. of Vital Statistics

Of the 1,462 persons notified to return to the clinic for 14 x 17 films, 1,438 received satisfactory films and 24 did not return for retakes; 1,050 (71 per cent) of the 14 x 17 films showed abnormal densities. However, only 677 were considered serious enough to recommend further study and treatment (Table II).

*Read before a meeting of Pierce County Medical Society, Tacoma, Wash., March 14, 1950.

**Executive officer, Department of Public Health, Preventive Medicine, University of Washington School of Medicine.

Table II

Classification of 1462 Abnormal (70 m.m.) Screening Films by the Large Diagnostic Film (14" x 17")		
Classification	No.	%
Essentially Negative	388	27
Abnormal Densities		
Minor Abnormalities - No Follow-up) Recommended 373 or 25%)	1050	71
Definite Abnormalities - Follow-up) Recommended 677 or 46%)		
"Lost" from Study (did not return for 14" x 17" film)	24	2
Total	1462	100%

Appointments were made for the 677 patients to return to the clinic for an interpretation of the roentgen findings. In 20 cases, the patient's private physician asked that the patient return to his office for the interpretation and an additional 12 patients did not keep their appointments. Consequently, a total of 645 patients was interviewed for the study. The cases with a diagnosis of tuberculosis or suspected tuberculosis interviewed totalled 467 and the balance (178) of those interviewed had a variety of diagnoses with the majority classified as cardiac (Table III).

Table III

Tentative Diagnosis of All (1050) Films Revealing Any Increased Densities and Number Interviewed			
Diagnosis	Total No. Diagnosed	No. Recalled & Interviewed	% Recalled & Interviewed
Minimal Tbc.	325	137	42
Moderate Adv.	136	122	90
Far Adv.	11	11	79
Other Tbc.	61	34	56
Suspected Tbc.	163	163	100
Total Tbc.	699	467	67
Cardiac	111	95	86
Tumor	32	32	100
Silicosis	30	6	20
Miscellaneous	178	45	25
Total Non-Tbc.	351	178	51
Total All Cases	1050	645	61

* Presumably tuberculous lesions which could not be classified definitely in one of first three.

** Included questionable tuberculous lesions.

PATIENTS PRESENTING SUBJECTIVE SYMPTOMS

Symptoms which could reasonably result from the evidence presented by the roentgenogram, and as stated by the patients during the interviews with the clinic physicians, were present in 339 or 53 per cent of the 645 patients interviewed.

In many instances more than one symptom was manifest. Two hundred and twenty-four (48 per cent) of the 467 patients with a diagnosis of tuberculosis were found to have symptoms which could reasonably be caused by the patients' chest findings. In the nontuberculosis group of 178, 115 had subjective symptoms or 64.6 per cent (Table IV).

In the group with a diagnosis other than tuberculosis, silicosis appeared to show symptoms most frequently. However, since only 6 of the total 30

cases discovered were recalled for interview, these were undoubtedly the most severe. It would appear, therefore, that the cardiac cases apparently displayed symptoms most frequently (73 per cent) in the nontuberculous chest conditions in the study.

PATIENTS NOT SEEKING MEDICAL CARE AND THEIR REASONS

Of the 224 cases or suspected cases of tuberculosis exhibiting subjective symptoms, 147 or 66 per cent sought medical care while 77, or 34 per cent, did not (Table V).

The most frequent reason given by patients with a diagnosis of tuberculosis or suspected tuberculosis for not seeking medical care was a lack of understanding of the importance of the symptoms. This answer was given in 52 of the 77 cases or 68 per cent. The next most frequent reason was the statement that the symptoms were so mild or of such short duration the patient did not believe them to be of any importance. This answer could probably have been classified with the first reason above but was separated and accounted for 17 per cent of the answers. Five per cent of the patients gave financial reasons for not seeking care (Table VI).

In the individuals with a diagnosis other than tuberculosis, only 15 of the 115 with symptoms did not seek medical care or 13 per cent (Table VII).

Table IV

Cases Presenting Symptoms Chargeable to Chest Pathology Interviewed (645 Cases)						
	Min. Tbc.	Mod. Adv. Tbc.	Far Adv. Tbc.	Other Tbc.	Susp. Tbc.	Total
No. Diagnosed	137	122	11	34	163	467
No. Having Symptoms	58	65	8	31	62	224
% With Symptoms	42	53	73	91	38	48

Other Diagnosis - Excluding Tbc.

	Cardiac	Tumor	Silicosis	Misc.	Total
No. Diagnosed	95	32	6	45	178
No. Having Symptoms	69	14	5	27	115
% With Symptoms	73	44	93	60	65

Table V

Tuberculosis Cases With Symptoms Not Seeking Medical Care					
Diagnosis	No. Interviewed	Symptoms		Not Seeking Medical Care	
		No.	%	No.	%
Minimal Tbc.	137	58	42	20	35
Mod. Adv.	122	65	53	24	37
Far Adv.	11	8	73	1	13
Other Tbc.	34	31	91	1	3
Suspected Tbc.	163	62	38	31	50
Total	467	224	48	77	34

The number of cases having symptoms with a diagnosis other than tuberculosis, who did not seek medical care, is too small to be significant but again a lack of understanding of the importance of the symptoms was given as the patient's reason most frequently (Table VIII).

PATIENTS' REASONS FOR NOT FOLLOWING THEIR PHYSICIANS' RECOMMENDATIONS

In the tuberculosis group, the frequency of not following the physician's recommendation was 45 or 31 per cent of the 147 total seeking medical care. The highest frequency occurred in the moderately advanced group (Table IX).

A misunderstanding of the importance of symptoms experienced was the most frequent reason given by the tuberculosis group for not following the recommendations of the physician (39 per cent). A lack of confidence in medical science, fear and financial reasons ranked next in descending frequency (Table X).

The number of persons who sought medical care in the nontuberculous group, but who did not follow the recommendations of their physicians was almost the same percentage as in the cases with a diagnosis of tuberculosis, the former being 31 per cent and the latter being 32 per cent (Table XI).

The number of nontuberculosis cases not following the recommendations of their physicians is small but economic reasons outranked the other reasons for the first time (Table XII).

In summarizing the data on all the cases not consulting a physician after definite symptoms were shown to be present, it was found that a lack of understanding of the importance of the symptoms present was by a large majority the most frequent explanation for failure to obtain treatment and was given by 70 per cent of the cases. When the patients, who did not follow the recommendations of their physicians, are combined, the distribution of the reasons given was more equally divided among the total group of reasons (Table XIII). In combining both the group who did not seek medical care and the group who did not follow recommendations, misunderstanding of the importance of the symptoms was the reason given by 52 per cent of the cases and economic reasons ranked second and accounted for 12 per cent of the reasons.

DISCUSSION

Before the findings of this study are considered, it must be emphasized that there are many factors which are present to bias the survey. In the first place, the number of patients involved in the various classifications is very small. The honesty of the patient's answers might well be challenged. All of the 1050 cases with abnormal findings were not recalled for interview nor was any representative sampling taken of this group or the small group

Table VI

Patient's Reason for Not Seeking Medical Care (Tuberculosis)						
	Minimal	Mod. Adv.	Far Adv.	Other Tbc.	Suspected Tbc.	Total %
Fear		2				2 3
Economic		3		1		4 5
Misunderstood Importance	14	14	1		23	52 58
Symptoms Mild or Short Duration	4	4			5	13 17
Lack of Confidence in Medical Science					1	1 1
Other Reasons	2	1			1	4 5
None Stated					1	1 1
Total	20	24	1	1	31	77 100

Table VII

Non-Tuberculosis Cases With Symptoms Not Seeking Medical Care

Diagnosis	No. Interviewed	Symptoms		Not Seeking Medical Care	
		No.	%	No.	%
Cardiac	95	69	73	5	7
Tumor	32	14	44	4	29
Silicosis	6	5	83	2	40
Misc.	45	27	60	4	15
Total	178	115	65	15	13

Table VIII

Patient's Reason for Not Seeking Medical Care (Chest Pathology, Exclusive of Tuberculosis)

	Cardiac	Tumor	Silicosis	Misc.	Total	%
Fear						0
Economic						0
Misunderstood Importance	3	4	2	3	12	80
Symptoms Mild or Short Duration	1			1	2	13
Lack of Confidence in Medical Science	1				1	7
Other Reasons						0
None Stated						0
Total	5	4	2	4	15	100

referred directly to private physicians and those not appearing for interview. These exclusions include some with disease, some with symptoms, some seeking medical care, etc. Less than half of the population over 15 years of age (46 per cent) were screened, thus the incidence of chest pathology and reasons for patients not obtaining care could vary greatly, since persons may volunteer for roentgen or refuse it for any reason.

The results cannot honestly be applied to the adult population of Pierce County, since it cannot be stated that the survey is or is not representative of the general population over fifteen years of age. Other biases are probably present. Therefore,

Table IX

Tuberculosis Cases With Symptoms Who Sought Medical Care, but Did Not Follow Recommendations

Diagnosis	Visited Physician	Did Not Follow Recommendation	%
Minimal Tbc.	38	9	24
Moderate Adv.	41	16	39
Far Adv.	7	2	29
Other Tbc.	30	7	23
Suspected Tbc.	31	11	36
Total	147	45	31

Table I

Patient's Reason for Not Following Recommendations of the Physician (Tuberculosis)

	Min- imal	Mod. Adv.	Far Adv.	Other Tbc.	Sus- pected Tbc.	Total	%
Fear	3	1		1	1	6	13
Economic	2		1		2	5	11
Misunderstood Importance	1	8		4	4	17	39
Symptoms Mild or Short Duration		1				1	2
Lack of Confidence in Medical Science		4			3	8	18
Other Reasons	2	2		1	1	6	13
None Stated			1	1		2	4
Total	9	16	2	7	11	45	100

Table XI

Non-Tuberculosis Cases Who Sought Medical Care, but Did Not Follow Recommendations of the Physician

Diagnosis	Visited Physician	Did Not Follow Recommendation	%
Cardiac	64	22	34
Tumor	10	4	40
Silicosis	3	2	67
Misc.	23	4	17
Total	100	32	32

strictly speaking, the findings of the survey are true only within the limitations of the survey itself.

The study, however, presents some interesting factors. In Table XIII it is noted that four patients classified as tuberculous gave "economic" reasons for not seeking medical care and five gave similar reasons for not following the recommendations of their physicians. In Pierce County diagnosis and sanitarium care are provided free by the County-City Health Department without any means test.

Table XII

Patient's Reason for Not Following Recommendation of the Physician (Chest Pathology, Exclusive of Tuberculosis)

	Cardiac	Tumor	Silicosis	Misc.	Total	%
Fear	2	1			3	9
Economic	9	2		1	12	38
Misunderstood Importance	6			1	7	22
Symptoms Mild or Short Duration					0	
Lack of Confidence in Medical Science	4	1	1	1	7	22
Other Reasons	1		1	1	3	9
None Stated					0	
Total	22	4	2	4	32	100

Table XIII

Combined Reasons Given By Patients for Either Not Seeking Care, or for Not Following Recommendations (All Diagnoses)

	Not Seeking Care				Not Following Recommendations				Total Both	
	Tbc.	Other	Total	%	Tbc.	Other	Total	%	All Diagnoses	%
Fear	2	0	2	2	6	3	9	12	11	7
Economic	4	0	4	4	5	12	17	22	21	12
Misunderstood Importance	52	12	64	70	17	7	24	31	88	52
Symptoms Mild or Short Duration	13	2	15	16	1	0	1	1	16	10
Lack of Confidence in Medical Science	1	1	2	2	8	7	15	19	17	10
Other Reasons	4	0	4	4	6	3	9	12	13	8
None Stated	1	0	1	1	2	0	2	2	3	1
Total	77	15	92	100	45	32	77	100	169	100

If the bread-winner is hospitalized for tuberculosis, the family is supported by the welfare department where need is demonstrated.

Perhaps one of the most interesting factors in the survey was the large percentage of persons in the tuberculosis classification who claimed a "lack of understanding of the importance of their symptoms," for either not consulting a physician or for not following recommendations. The local tuberculosis league and the health department have carried on extensive health education activities for the lay public concerning tuberculosis for many years. This lack of understanding seemed to decrease after a physician was consulted but the "lack of confidence in medical science" reason increased. The economic reason for not seeking care or following recommendations for all diagnoses in the persons included in this survey is small (12 per cent).

The method of the survey here reported is one of direct approach to the patient in an attempt to determine what factors keep people from medical care when there is a definite reason for care and why some people, even after consulting a physician, do not carry out the treatment prescribed. While the study is small and involves only the chest, it would appear that, if additional similar studies

could be made on larger groups and for other conditions and the technic could be improved to a point where the results were more reliable, it might be possible to better determine the actual true needs of the public in regard to medical care.

SUMMARY

- 1. A direct approach method is reported for determining reasons why patients, who have proven pathology in the thoracic cavity and symptoms present, either do not seek medical care or, when they do, do not follow the recommendations of their physicians.
- 2. The combined reasons given by patients for either not seeking care, or not following their physicians' recommendations in order of frequency are:

	<i>Per Cent</i>
a. Misunderstanding of importance of the symptoms	52
b. Economic	12
c. Symptoms mild or short duration....	10
d. Lack of confidence in medical science	10
e. Miscellaneous	8
f. Fear	7
g. Not stated	1

- 3. It is suggested that the method be used in larger groups of patients and other demonstrable pathologic conditions to test its general validity in further attempts to determine directly how frequently definitely ill persons do not receive proper medical care because of financial reasons.

Present-Day Concepts of Immunizations of Infants*

By E. ALBERT MOODY, M.D.
BEND, ORE.

THERE has been a recent trend to immunize infants at an earlier age than has been the custom in the past. Early immunization of infants has been chiefly concerned with protection against pertussis. Pertussis caused the deaths of 10,730 children between 1938 and 1940, of which 67 per cent were under one year and 47 per cent were under seven months of age.¹ In a recent survey of bronchiectasis in England Field reported pertussis second only to pneumonia in predisposing to this disease.²

The decline in cases of clinical diphtheria indicate less urgency in early immunization against this disease. However, diphtheria toxoid is now conveniently combined with pertussis vaccine and tetanus toxoid so that the physician may immunize against all three diseases and thus obviate the necessity of several courses of immunizations. In the case of tetanus toxoid, the unfavorable reactions to tetanus antitoxin and the occurrence of clinical tetanus from insignificant injuries are arguments in favor of its inclusion.

The main arguments against early immunization of infants have been the generally conceded immaturity of the immune mechanism in the newborn infants and the interference with active immunization by passively inherited maternal antibodies. In 1938, McKhann pointed out that the newborn infant is immune to many diseases by reason of

passive transfer of antibodies from the mother.³ After this immunity is lost, the infant becomes more susceptible than the older child. This susceptibility appears to depend on a deficiency in the ability to produce antibodies associated with a low level of natural antibodies such as isoagglutinins and heterophile antibodies. He concluded that a lessened response to active immunization must be expected in infants and that a further diminution in response occurs, if immunization is attempted before the natural immunity is lost.

Sauer's early work supported this belief. In 1941 he showed that pertussis occurred seven times more frequently in children immunized before the third month of life than in children immunized after six months.⁴

With the advent of alum precipitated and aluminum hydroxide adsorbed vaccines, the possibility of satisfactory early immunization of infants was revised and several workers were able to demonstrate better results than had been achieved earlier. Sako⁵ obtained highly satisfactory results by immunizing infants from two to twelve weeks of age with three injections of alum precipitated vaccine. From 78 to 80 per cent. of the infants achieved satisfactory antibody levels against pertussis as determined by macroscopic agglutination test of Miller and Silverberg and the rapid slide agglutination test of Powell and Jameson. Sako was also

*Read before the Seventy-Sixth Annual Meeting of Oregon State Medical Society at Gearhart, Ore., Sept. 27-29, 1950.
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2. Field, C. E.: Bronchiectasis in Childhood, I. Clinical Survey of 160 Cases. *Pediatrics*, 4:21-46, July, 1949.

3. McKhann, C. F. and Kapnick, I.: Immunity and Susceptibility to Disease in Early Infancy. *J. Pediat.*, 13:907-918, Dec., 1938.
4. Sauer, L. W.: Age Factor in Active Immunization Against Whooping Cough. *Am. J. Path.*, 17:719-723, Sept., 1941.
5. Sako, W.: Studies on Pertussis Immunization. *J. Ped.*, 30:29-40, Jan., 1947.

able to show maintenance of a high antibody level for at least two years and clinical protection when the immunized infants were intimately exposed to pertussis. From his studies he concluded that age made no difference in the ability of infants to achieve protection against pertussis by active immunization.

His results were duplicated by Halpern and Halpern⁶ in 1948 and these investigators were also able to show the correlation of macroscopic agglutination titers with the Flosdorf skin test. Further clinical confirmation was reported by Bell,⁷ who administered alternately two doses each of alum precipitated diphtheria toxoid containing *H. pertussis* vaccine and alum precipitated diphtheria toxoid alone to 1,238 children, ages two to twelve months. Only forty-eight cases of pertussis occurred in the immunized infants, compared with 158 in the control group, and a further breakdown showed no significant difference in the attack rate among the protected children, regardless of the age at which immunizations were begun.

In 1949, Di Sant Agnese^{8,9,10} made an exhaustive study of early immunizations and found higher antibody titers and a longer duration of immunity when infants were immunized after six months, compared with immunization begun at one week of age. He had no figures, however, for infants immunized between one and six months. In the same year, Miller^{11,12} was able to show very satisfactory results when immunizations were begun at four to six weeks of age, providing alum precipitated vaccine was used. He was able to protect 62.2 per cent of infants with a total dose of 40 billion organisms. Bradford¹³ was able to achieve protective (1:320) titers in only a few of his series by immunizing as early as four to six weeks of age but felt that probably 75 per cent of the infants had protective levels if exposed to the disease.

The interference with active immunization by

passively inherited maternal antibodies has been shown by several investigators. Cooke¹⁴ found, in a group immunized between one and three months, only 30 per cent of those with maternal antibodies achieved a level of .1 unit of diphtheria antitoxin against 82 per cent of those without these antibodies. This work was duplicated by Greenberg and Fleming¹⁵ but these investigators questioned the importance of this finding since both groups did achieve antibody levels greater than .004 units per cc., the amount which would result in Schick negativity.

Di Sant Agnese found in his series that fewer infants with high titers of maternal antibody at birth maintained a high titer after the "booster" injection than those with little or no maternal antibody. Bradford feels that the factor of maternal antibodies will become less important with the continuing decline in clinical diphtheria and the resulting decline in the numbers of mothers with high titers of diphtheria antitoxin at the time of delivery.

Reactions have generally become fewer and less severe with improvement in the materials used. All observers are of the opinion that the younger infants have fewer and less severe reactions than the older infants. The use of the deep intramuscular injection is generally preferred with most investigators, favoring the buttocks as the best site for the injections since this site provides the largest muscle mass. The occurrence of higher titers, when reactions do occur, is some consolation to the physician who must explain these reactions to the parents.

SUMMARY

It is obvious that there are two contradicting facts in this discussion. First is the young infant's susceptibility to pertussis and the need to protect him by active immunization if possible; second, the young infant, by reason of the immaturity of his immune mechanism and the interference with active immunization by passively inherited maternal antibodies, does not respond as well to active immunization as the older infant. However, this last fact is gradually being overcome by the use of alum precipitated and aluminum hydroxide adsorbed vaccines so that a high percentage of young infants can be protected against pertussis. It is my opinion that immunizations should be started early in life, preferably at four to six weeks of age. This will effect at least a partial protection against pertussis at an age when its mortality is the highest.

6. Halpern, S. R. and Halpern, D.: Early Whooping Cough Immunization. *J. Pediat.*, 33:43-48, July, 1948.

7. Bell, J. A.: Pertussis Immunization. *J. A. M. A.*, 137:1276-1281, Aug. 7, 1948.

8. Di Sant Agnese, P. A.: Combined Immunization Against Diphtheria, Tetanus and Pertussis in Newborn Infants, I. Production of Antibodies in Early Infancy. *Pediatrics*, 3:20-33, Jan., 1949.

9. Di Sant Agnese, P. A.: Combined Immunization Against Diphtheria, Tetanus and Pertussis in Newborn Infants, II. Duration of Antibody Levels. *Pediatrics*, 3:181-194, Feb., 1949.

10. Di Sant Agnese, P. A.: Combined Immunization Against Diphtheria, Tetanus and Pertussis in Newborn Infants, III. Relationship of Age to Antibody Production. *Pediatrics*, 3:333-344, March, 1949.

11. Miller, J. J. and Ryan, M. D.: Immunization with Combined Diphtheria and Tetanus Toxoids (Aluminum Hydroxide Adsorbed) Containing *H. Pertussis* Vaccine. *Pediatrics*, 1:8-22, Jan., 1948.

12. Miller, J. J., Faber, H. K., Ryan, M. L., Silverberg, R. J., and Lew, E.: Immunization Against Pertussis During First Four Months of Life. *Pediatrics*, 4:468-478, Oct., 1949.

13. Bradford, W. L., Day, E. and Martin, F. J.: Humoral Antibody Formation in Infants Aged One to Three Months Injected with Triple Alum Antigen. *Pediatrics*, 4:711-718, Dec., 1949.

14. Cooke, J. V.: Antibody Formation in Early Infancy Against Diphtheria and Tetanus Toxoid. *J. Pediat.*, 33:141-146, Aug., 1948.

15. Greenberg, L. and Fleming, D. S.: The Effect of Inherited Antibodies on Active Immunization of Infants. *J. Pediat.*, 36:143-148, Feb., 1950.

The following is a suggested schedule of immunizations:

Four to six weeks: .5 cc. of alum precipitated or aluminum hydroxide adsorbed pertussis vaccine containing diphtheria and tetanus toxoid.

Eight to ten weeks: Repeat above dose.

Twelve to fourteen weeks: Repeat above dose (total dose of 40 billion *H. pertussis* organisms).

Four to five months: Smallpox vaccination.

Nine to ten months: .5 cc. of alum precipitated or aluminum hydroxide adsorbed pertussis vaccine containing diphtheria and tetanus toxoid (stimulating dose).

Stimulating injections of "DPT" should be given annually until the age of six years and every three years thereafter. Smallpox vaccination should be

repeated on entrance to school and every five years thereafter.

CONCLUSIONS

1. Early immunization of infants against pertussis, diphtheria and tetanus is a practical and necessary procedure, even though better results will be obtained by beginning immunization later in infancy.

2. Alum precipitated or aluminum hydroxide adsorbed vaccines should be used.

3. An immunization schedule is suggested with the first injection beginning at four to six weeks of age.

The Female Urethra and Chronic Urethritis*

GORDON W. REYNOLDS, M.D.

IDAHO FALLS, IDA.

THE female urethra is gradually receiving long-deserved recognition as a cause of many chronic urinary conditions. Injuries, with the exception of trauma at childbirth, are infrequent. Chronic urethritis, strictures, tumors and prolapse are common. This study will confine itself to the urethritides.

Very apropos is a statement of Dr. Hugh Cabot of Boston which has been paraphrased as follows: "Any pain within two feet of the female urethra, which does not seem to be adequately accounted for by some definite pathologic change, should be suspected as being due to the urethra!"

ANATOMY AND PHYSIOLOGY

In order to have a good understanding of the pathologic conditions to which the urethra is susceptible, it is necessary to have a picture of the anatomy and physiology in mind. The urinary meatus in the female is a slit about 5 mm. in diameter located between the urethral labia and labia minora, about 2 cm. below the clitoris.

The urethra itself is a canal measuring 2.5 to 3.5 cm. in length which follows a slightly curved direction downward and forward below and behind the lower border of the symphysis pubis. It is surrounded by a dense mass of smooth muscle fibers continuous with the bladder wall as it leaves the bladder. As it leaves the pelvis minor, it pierces the urogenital diaphragm and the portions between the superior and inferior layers of this diaphragm are surrounded by fibers of the sphincter urethrae membranaceae.

Except during the passage of fluid, the canal is closed by apposition of its anterior and posterior walls. The posterior wall of the urethra, except

in its upper part, is very intimately connected with the anterior wall of the vagina and, as it approaches the external urethral orifice, is practically imbedded in the anterior vaginal wall.

The mucous lining of the canal is raised into a number of longitudinal folds. One of these, more distinct than the others and placed upon the posterior wall of the passage, is called the crista urethralis.

The thick muscular wall of the female urethra is connected by fibrous tissue to the back of the pubis and to the fascia over the lower part of the levator ani muscles. It is continuous above with that of the bladder and is composed of layers of circularly disposed smooth muscle fibres together with a few bundles which are longitudinally directed.

The blood supply of the female urethra is derived from the inferior vesical and branches from the internal pudic arteries. The veins drain into the pudic and vesicovaginal plexuses. The lymphatics empty into the deep inguinal, external iliac and hypogastric nodes. Innervation is from the hypogastric and pudic plexuses.

The function of the urethra in the female is solely for the purpose of conveyance of urine from the bladder. Retention of fluid in the bladder is dependent upon muscular closure of the canal. The chief factor in this closure is the voluntary sphincter. The female urethra in its entirety corresponds to the posterior urethra in the male. The structure, innervation and blood supply of the wall and its adaptability to the function of micturition are practically identical in the two sexes.

PARAURETHRAL GLANDS

Numerous minute urethral glands and pitlike urethral lacunae open into the urethra. One group

*Read before Watts Hospital Medical Staff meeting, Durham, North Carolina, May, 1947.

of these glands on either side possesses a minute common duct known as the paraurethral duct. These latter glands, according to some investigators, represent the homologue of the male prostate gland. They are the largest of the paraurethral glands and are called Skene's glands. Their terminal alveoli are lined by tall columnar epithelium and the ducts close to the outlet are lined by transitional epithelium.

Deter, Caldwell and Folsom¹ have made a most complete study of the female urethra with emphasis on the part played by the paraurethral glands in chronic urethritis.

As early as 1672, deGraef reported on these glands and stressed the fact that they constituted a female prostate. Similar observations have been made by others, including Skene, who described the ducts of certain of the glands as being homologues of the prostatic ducts in the male. Petrowa approached the problem embryologically and came to the definite conclusion that there is complete analogy so far as the glandular system is concerned in the development of the urethra in both sexes.

CHRONIC URETHRITIS

Clinically, conditions of the female urethra may be divided into three main classes: Acute and chronic infections which may be subdivided into specific and nonspecific urethritides, benign and malignant tumors and other conditions such as stricture and prolapse. By far the most common of these conditions is chronic nonspecific urethritis. It is seen more commonly in the female but the same type of bacteria invade both sexes, mainly the colon bacillus and the streptococcus.

ETIOLOGY

Acute infections of the female urethra, which are the forerunners of chronic infections, may be initiated by a number of conditions: Traumatism due to difficult labor, presence of foreign bodies such as calculi, focal infections elsewhere in the body which may set up an interstitial urethritis, dietary errors, highly acid urine, alcoholic excess, constricted meatus which does not allow proper drainage, prolonged, too vigorous or too frequent instrumentation, recent marriage or other changes in the glandular system, infection secondary to a primary cystitis or pyelonephritis.

Chronic infection in the female urethra is much more common than is generally believed. The close anatomic relationship between the urinary and genital canals in the female make it possible that infection in one tract may be easily communicated to the other. Gynecologists often see a simultaneous cervicitis and urethritis. The external urethral meatus is often located high in the vaginal introitus,

a region which is peculiarly exposed to bacterial invasion and generally bathed in infected secretions. Its liability to infections is thus enhanced, especially if the meatus be congenitally narrowed so that free drainage is impaired.

In infancy it is also exposed to feces, and this may well account for the fact that pyelitis is seen ten times more frequently in female babies than in male. If the urethra were a simple tube, contaminants would be washed out easily with urination but, with glands in this posterior urethra, they are everready receptacles for receiving these materials and acting as depots for their distribution to the upper urinary tract.

Posterior urethral obstructions in females are not new entities. The accurate interpretations of clinical findings are, however, of more recent date. In the long experience of Folsom, after finding a normal bladder and upper urinary tract, all too many women have been told that their troubles were "in the head, not in the other end," and the suggestion made to forget their bladder. All the time the urethra, and not the bladder, was at fault. Similarly, Moore² found, in twenty-three years of the practice of urology, that 75 per cent of all female patients seen had definite urethral disturbances. I quote as follows from his paper: "Anatomically, the urethra is so constructed and situated that the wonder is how it ever escapes infection after the first cohabitation. The natural function of early married life is the forerunner of more urethrocystitis than is ever commonly suspected by the medical profession. Many agree with Folsom that urethral infections, regardless of how contracted, probably enter the lymphatics and may ultimately reach the kidney pelvis."

The studies of Folsom and his associates concerning the analogy between the posterior urethral glands in the female and the prostate in the male have been mentioned. In 1932, Moore and his associates did work on this subject from a clinical standpoint and came to the conclusion that there is some foundation for the opinion that hormones play some part in the etiology of female posterior urethritis. They found that gonad hormones stimulate homologous reproductive accessories but are without effect on heterologous accessories. Thus, male hormones have no effect on the female system after ovariectomy. They do, however, stimulate vestigial structures in the female which are homologous to the male.

Therefore, it is not too difficult to visualize a case in which the normal hormone balance is altered (such as at the menopause, puberty or following marriage), in which the posterior urethral

1. Deter, R. L.; Caldwell, G. T., and Folsom, A. L., *Clinical and Pathological Study of Posterior Female Urethra*, J. Urol., 55:651-662, June, 1946.

2. Moore, N. S., *Problems Involving Female Urethra: Suggestions as to Therapy*, South. M. J., 38:149-150, Feb., 1945.

glands, otherwise inactive, would undergo hypertrophy. As the result of this, these glands would be more susceptible to infection. Many cases of urethritis are seen just preceding or just after the onset of puberty. Pyelitis of pregnancy is well known, as is the so-called "honeymoon cystitis" and, lastly, the largest group of these cases is seen at the time of the menopause.

DIAGNOSIS

Diagnosis is not difficult except that the symptoms are often those of any other urinary tract infection. The most outstanding symptom is frequency. This, accompanied by nocturia, burning, sensation of incomplete emptying of the bladder and pain referred to the back or along the ureters constitute the usual picture in a highly nervous woman. Terminal hematuria, as evidenced by a drop of blood on the paper following urination, is occasionally the symptom which brings them to see the doctor.

Final diagnosis is made by cystourethrosopic disclosure of inflammatory changes along the urethra, plus exclusion of pathology elsewhere in the urinary tract. Skene's and other paraurethral glands should be carefully studied in an effort to locate infective foci.

TREATMENT

Treatment is comparatively easy after a definite diagnosis has been made as symptoms subside rapidly upon removal of the cause. Older methods consist of irrigations, local application of silver nitrate, etc. These have, for the most part, given

way to dilatations, chemotherapy and fulguration.

Most mild cases respond very nicely to such relatively simple office procedures as dilatations with sounds of increasing calibre, followed by the instillation of an ounce of 5 per cent argyrol in the bladder. These treatments should first be given twice weekly for about two weeks, then weekly and finally at much longer intervals. Dilatation of this type "irons out the folds" of the urethra, giving better drainage of the paraurethral glands, stimulating circulation and promoting rapid healing, especially when small doses ($7\frac{1}{2}$ gr. q.i.d.) of one of the triple-sulfonamides are given as an adjunct.

In cases of longer standing, where definite pathologic changes have taken place such as formation of polyps or actual stricture in the posterior urethra, more radical measures must be considered. Arrange to give these patients a small spinal anesthetic, express any pus from the paraurethral glands and lightly touch the mucous membranes of the canal and adjacent trigone with unipolar cautery.

If there is much fibrosis or sclerosis of the bladder neck, a resectoscope may be used to take a few "bites" of this tissue in much the same manner that a transurethral resection is done on the male prostate.

An indwelling catheter is now left in place for from twenty-four to forty-eight hours, the patient is placed on chemotherapy and follow-up treatment initiated as was described above under office treatment. It is safe to say that eight out of ten women afflicted with this condition will notice a definite improvement within a matter of days.

Exstrophy of the Bladder*

A. H. PEACOCK, M.D., and SYLVAN STOOL, M.D.
SEATTLE, WASH.

BY THIS TERM is indicated absence of the lower abdominal wall (suprapubic) and the anterior wall of the bladder. The posterior wall of the bladder bulges forward, exposing the mucous membrane and prominences of the ureteral orifices. Exstrophy may be complete or incomplete; the former predominates. The surface of the bladder presents a raw, bleeding appearance, wet with spurts of urine and excoriation of the adjacent skin of the abdomen, thighs and buttocks.

There is a wide separation of the pubic bones and genital anomalies, as cryptorchidism, cleft scrotum, rudimentary penis in the male, cleft clitoris, undeveloped labia and vagina in the female. Spina bifida, cleft palate, harelip or some of the many other anomalies may also be present.

The symptoms are largely those due to constant saturation with urine. The occurrence is approximately once in every 50,000 births and eight males to each female involved.

TREATMENT

All early operations had as their object closing of the bladder. Even these, when fairly successful, failed to establish urinary control, leakage persisting. It must be remembered that not only is there a total absence of that part of the abdominal wall covering the bladder and the bony symphysis, but also, most important, there is absence of the sphincters of the urethra.

These many types of operations have been abandoned in favor of implantation of the ureters into the sigmoid. Since the British surgeon, John Simon, in 1851 first transplanted the ureter into the lower colon in man, countless attempts have been made

*Read before a meeting of Seattle Surgical Society, Seattle, Wash., February 11, 1950.

in animal experiments to make this a safe and satisfactory procedure.

HISTORICAL

John Simon, the British surgeon, in 1851 did first intestinal transplant in man, performed a plastic operation on one of these exstrophies which was not perfect, the patient remaining wet and without control of his urine. All early operations were aimed at creating another vesical or cavity in which to contain the urine. It was found, however, that the total absence often of the abdominal wall made this procedure most difficult and impossible.

British surgeon, Michon,¹ preferred the plastic repair of the bladder. He succeeded fairly well in reconstructing the bladder but found it difficult to control the urine. However, he reports success in five out of six cases.

Wilhelmi and Hammond² state that this condition is never seen in the lower animals. They operated one case, a male, 37 years of age. They did a two-stage operation on him. The patient also had a double hernia which is rather common.

Counseller³ states that half of these patients are dead by the tenth year, two-thirds by the twentieth year, chiefly from renal infection. He believes that the fifth year is the best time to attack the problem. The tissues at that time are better developed and the bowel control is also improved. Fifty per cent of the deaths after operation are due to pyelonephritis, ureteritis, peritonitis and obstruction. The second choice is cutaneous ureterostomy; the third is nephrostomy. Antibiotics have helped a great deal in controlling infection during these operations.

Rubovits and Arnkoff⁴ give the history of pregnancy associated with exstrophy of the bladder, collecting some 33 children born to 26 exstrophic mothers. They added one of their own, a colored female, 31 years of age. Their attempts to repair this one were unsuccessful.

Rizzi⁵ reported four cases in which he had done a cystosigmoidostomy for vesical exstrophy. He sutures the bladder wall laterally to the sigmoid. His results are not reported.

Higgins,⁶ who has had the largest number of cases in the literature, in 1947 reported 41 cases. He recommends ureterosigmoidostomy entirely. He feels that the operation should be done during the first year of life for the following reasons:

1. Infants tolerate surgery much better at this age than later.
2. In the later years pyelonephritis is very apt to develop.
3. There are fewer organisms in the bowel of infants and they can be much easier sterilized.
4. Early operation permits normal development of the child. Frequently they have an inferiority complex due to their deformity and cannot act as other children.
5. The mortality in infants is much lower than in operations performed later.

The literature shows a number of cases in which the reporter has had one case with varying results. It has been rather difficult to follow up all of these reports.

CASE REPORT

The case shown this morning is a white female child, one year of age, admitted to the Children's Orthopedic Hospital October 21, 1949. The family history and birth history were negative. The father was 23 years of age and mother 20 years, both apparently in average health, and she is the only child. Her birth weight was 7 pounds, 9 ounces. In taking the history no other anomalies were reported in either of the parents' families.

There had been no history of illness in this infant, except that she had been a little bit hard to feed. The examination showed her height was 27 inches, weight 19½ pounds. The chest and lungs were normal. The abdomen showed absence of the lower part of the abdominal wall and projection of the fluctuating bladder. Around the margin of this prolapse could be seen a marked excoriation of the skin of the lower abdomen, the thighs and buttocks. This was ulcerated in spots and bled easily. The orifices of the ureters were readily identified by spurts of clear urine.

There was no suggestion of a vagina. The anus looked normal; it did not protrude. There was a small scar at the upper edge of the bladder-cutaneous border which suggested an umbilicus. There was no other umbilicus seen.

Her blood count was normal. The N.P.N. was 27.2 mg. and an intravenous urogram showed normal kidneys and ureters. On November 11 a right uretero-sigmoidostomy was performed. Postoperatively there was some trouble in getting her to take fluids but the course was otherwise uneventful. At this time it was found that she had a normal uterus, fallopian tubes and ovaries. A careful search for a vaginal tract was made but none was found.

On November 29 the left ureter was transplanted. This ureter was a little difficult to find, being under the sigmoid, but was easily traced by passing a probe through the exposed meatus of the ureter. Both of these ureters were planted obliquely in the sigmoid. The postoperative N.P.N. was 45.3 mg. but she did well and had normal bowel movements. She was discharged on the fortieth postoperative day for further recuperation.

Pyelograms made six weeks later revealed a mild bilateral hydronephrosis. The excoriation of the buttocks had now cleared up.

On January 20 the bladder was excised and a plastic operation done on the abdominal muscles and fascia, closing the defect in the lower abdominal wall. The postoperative course was smooth and the wound was healed well without evidence of infection.

Twenty-three cases of exstrophy of the urinary bladder have been operated on by members of the staff of the Children's Orthopedic Hospital

1. Michon, L., Conservative Operations for Exstrophy of the Bladder, with Particular Reference to Urinary Continence, *Brit. J. Urol.*, 20:167-174, Dec., 1948.

2. Wilhelmi, O. J., Exstrophy of Bladder with Pyelographic Follow-up, *J. Urol.*, 59:1108-1120, June, 1948.

3. Counseller, V. S., Exstrophy of Bladder, *Surg., Gynec. & Obst.*, 88:401-403, March, 1949.

4. Rubovits, F. E., Pregnancy Associated with Exstrophy of the Bladder, *J. Urol.*, 62:52-57, July, 1949.

5. Rizzi, R., Cysto-Sigmoidostomy for Vesical Exstrophy, *Urol. & Cutan. Rev.*, 52:518-521, Sept., 1948.

6. Higgins, C. C., Transplantation of Ureters into Rectosigmoid for Exstrophy of Bladder; Review of 41 Cases, *J. Urol.*, 57:693-700, April, 1947.

over a period of the past 26 years, of which we have records. Nine of these were females and thirteen males which is contrary to the often published figures of one female to eight males. The incidence of this lesion is given by most writers as one in 40,000 to 50,000 births.

In Providence Hospital in Seattle in the past ten years there have been 21,982 births with one exstrophy, a female. In the past 27 years at the Swedish Hospital, Seattle, there have been 34,563

births with two exstrophies, both males, one being a stillborn. This would make it one in 17,000 at Swedish Hospital and one in roughly 22,000 at Providence.

An accurate followup has been rather difficult but the important complications have been inguinal hernia, ventral hernia, evisceration, hydronephrosis and pyelonephritis. We believe with Higgins that early transplantation of the ureters is most important.

Topical Cortisone in Eye Disease

CARL D. F. JENSEN, M.D., and JAMES F. WARD, M.D.
SEATTLE, WASH.

TREATMENT of a host of systemic diseases with ACTH and cortisone has been so dramatically successful that it has effected a revolutionary change in the present concepts of disease processes. The same has been true in regard to treatment of many anterior and posterior segment eye diseases.

Even more recently it has been found that many inflammatory diseases of the anterior segment of the eye respond just as dramatically to simple instillation of cortisone drops. That this should be so is of profound and far-reaching value and interest. It means that:

1. Many common eye diseases for which there has been little or no therapeutic specific will yield promptly to treatment.

2. Many lacerated and otherwise traumatized eyes that would have been lost previously will now be saved.

3. Topical instillation of cortisone is inexpensive.

4. No side effects or undesirable therapeutic extension effects were noted.

5. Subconjunctival injection of cortisone may supercede instillation for some purposes but it is too early to state definitely.

It is of the greatest interest that such a highly specific molecule as cortisone can exert its effect at the local tissue level, which ACTH is incapable of doing. It is obvious that the mechanism through which cortisone exerts its action at this level is unknown. It is not the purpose of this paper to review the systemic hormono-chemical effect of cortisone, as this has been done adequately elsewhere. The marked specificity of action of this one of the many adrenal cortical hormones has been amply demonstrated systemically and its efficaciousness at the local tissue level is as exciting in its theoretical implications as it has been successful in its practical applications. Subconjunctival injection

of the 12 mgm. per cc. saline suspension may supercede instillation of drops into the eye for some cases and hyaluronidase may be added to facilitate its absorption.

The fact that we are beginning to understand the relation between the specificity of this commercially synthesized steroid and its complex structural stereochemistry (as shown in the related activity of Compound F) gives hopes of future progress. It has been suggested that the mode of action of this synthetic hormone of the adrenal glands is that of an ancillary to connective tissue collagen. We believe that this is an over-simplification and we feel that its mechanism of therapeusis is far more complex.

The cortisone as used in our topical and subconjunctival therapy in a series of thirteen patients with anterior segment eye disease was the Merck & Company Cortone Acetate in saline suspension. We have used principally the 25 mg. per cc. stock solution diluted with an equal volume of normal saline, one drop every hour. Occasionally, the full strength stock solution was used, with the only undesirable effect being a transient stinging and hyperemia. Some investigators have used as little as 5 mg. per cc. suspension with excellent results.

CASE REPORTS

All nonpertinent details of the general eye examination, fundus examination, laboratory work and slit lamp examination have been omitted from the following for the sake of brevity.

Case 1. Iritis, recurrent, of unknown etiology, in a 56-year-old female who had had two prior attacks in previous years, each of which had cleared very slowly after two or more weeks of typhoid fever therapy. The duration of the present attack before treatment was one week so that at the time of examination there were many fine keratic precipitates on the endothelium of the left eye, a dense flare in the anterior chamber, circumcorneal and ciliary injection and a fixed miotic pupil. Pain and lacrimation were present but the tension was normal. One hour after the first drop of cortisone was instilled the pain was

completely relieved although the pupil had been dilated with atropine on the previous day without relief of pain. Atropinization was continued concurrently with cortisone. After 24 hours of one drop 25 mg. per cc. of cortisone every hour the flare had almost disappeared. The ciliary injection was practically gone and the eye felt normal subjectively. Cortisone was continued every two hours for twenty-four hours night and day, then given three times daily for one week. Complete clearing of keratic precipitates and all evidences of iritis were noted with no recurrence in subsequent weeks.

Case 2. Iritis, recurrent, in a 32-year-old male of only a few days' duration. A moderately dense flare in the right eye which showed a muddy iris on gross examination, a miotic pupil despite self-administered atropine drops, was accompanied by considerable pain and a tension of 50 with the Schiotz' tonometer. Fifteen minutes after instillation of cortisone 12 mg. per cc. the pain disappeared. In one hour the flare in the anterior chamber was markedly less. The pupil had dilated and the ciliary injection was almost gone. Within two hours the eye was white, no anterior chamber flare was demonstrable with loupe and only occasional cells in the anterior chamber were seen with the slit lamp. The tension was now 40. Subjectively the patient felt well. The short duration of the acute attack was significant in the rapid subsidence of all signs and symptoms under cortisone therapy. We had never seen iritis treated by any form of therapy yield so magically and dramatically as in this instance. There was no recurrence.

Case 3. Female, 60 years of age, with postoperative diabetic iritis of the right eye. Following an uncomplicated intracapsular cataract extraction this patient developed an insidious postoperative diabetic iritis in the right eye culminating in a dense plastic exudate in the pupillary area, a very heavy flare in the anterior chamber seen with the slit lamp and a few keratic precipitates.

Twenty-four hours of instillation of cortisone 12 mg. per cc. produced virtual clearing of the flare and partial resolution of the plastic exudate on the pupillary border of the iris. Complete clearing of all signs and symptoms by the third day was noted. Following discharge from the hospital no cortisone was used and when the patient was seen in the office four days later the iritis had recurred. Upon administration by instillation of cortisone the second time the exudative iritis again yielded to topical cortisone and has not recurred.

Case 4. Thirty-five-year-old male with episcleritis, scleritis and sclerosing keratitis of the right eye of three years' duration with many partial remissions. Numerous laboratory tests were noninformative and treatment with a great variety of drugs, antibiotics and vaccines in the hands of a number of capable ophthalmologists were unavailing. The eye cleared dramatically after three days of topical cortisone, one drop 12 mg. per cc. every two hours, day and night. Vision improved in this case from c.f. at two feet to 20/40, corrected. The scleritis, episcleritis and ciliary injection disappeared. The aqueous flare disappeared. Photophobia, lacrimation and pain were eliminated. Sequelae: A few posterior synechia and ghost blood vessels in the cornea. There has been no recurrence in a three-month period.

Case 5. Traumatic iritis with penetrating wound of the cornea, iris and ciliary body in the right eye of a 43-year-old male. This patient was seen three hours after a 16-gauge iron wire had snapped back penetrating the globe, with loss of the anterior chamber. He was placed on local therapy with atropine, heat and systemic antibiotics. When seen on the following day the eye was much worse. The anterior chamber was over half filled with hyphema. The cornea was semi-opaque. The iris was barely

visible. There was swelling of the lids and chemosis of the conjunctiva. The puncture wound of the cornea near the limbus of the right eye had left a debris-filled path of entry with a hole through the iris probably extending into the ciliary body.

Threat of panophthalmitis was great and consideration was given to the possibility of draining the anterior chamber and flushing with antibiotic solution. Topical cortisone was begun every hour, 25 mg. per cc. and every two hours during the night. Within twenty-four hours a complete reversal of the process had begun. The hyphema had absorbed. Corneal opacification had lessened. The anterior chamber flare greatly lessened and the iris was clearly visible. Local reaction around the site of the injury had greatly diminished. Within seventy-two hours it became apparent that an eye which had appeared hopelessly and irrecoverably lost had been saved by cortisone therapy.

An interesting feature of the therapy appeared on the fourth day when the nightly instillation of drops had been discontinued due to the spectacular improvement. It was found that after eight hours without the drops the flare in the anterior chamber and the ciliary injection had partially recurred but promptly disappeared on instillation of cortisone. After the first week of topical therapy the anterior segment of the eye was clear but there were many minute vitreous opacities. At this time intramuscular cortisone was given, 300 mg. the first day in divided doses and 100 mg. per day on succeeding days. The vitreous opacities were lessened immediately. After the third day a one-day interim without therapy was observed following which there was an increase in vitreous opacities and the patient noted some increase in subjective blurring of vision, although the uncorrected vision at this time was 20/40. Reinstitution of systemic and topical cortisone produced clearing and the patient now appears well on the way to recovery.

Case 6. Quiet iritis in a 63-year-old male. Two weeks following extracapsular cataract extraction in the right eye an aqueous flare, ciliary injection and fine keratic precipitates were noted. The patient was started on topical cortisone and marked clearing of all signs of iritis was noted within twenty-four hours with complete clearing in seventy-two hours. Subconjunctival injection of 2 minims of 12 mg. per cc. were given. The deposit persisted for about three and one-half days before absorption was complete, being visible as a white subconjunctival fluid mass. No untoward effect was noted from this or from a subsequent injection. Final resolution of all signs and symptoms of the quiet iritis was the end result in this patient.

Case 7. Iritis of one month's duration in the left eye of a 30-year-old male. This patient's iritis had gone without treatment for one week when therapy with penicillin and atropine was started in another city without success. At the time he was seen in this office there was a dense aqueous flare in the left eye but there were no posterior synechia and very few keratic precipitates on the endothelium. The patient felt subjectively improved within one hour after the first drop of cortisone 25 mg. per cc. was instilled but the flare in the anterior chamber was still dense twenty-four hours later and did not clear for seventy-two hours. Following this the patient was continued for one week on cortisone drops three times a day and there has been no recurrence.

Case 8. Thirty-three-year-old male with a sector episcleritis of the right eye. Two drops of cortisone 12 mg. per cc. were instilled in the right eye ten minutes apart and subjective symptoms of a foreign body type of irritation were relieved immediately. No further treatment was given. The patient returned in four days and the eye was clear and there have been no further symptoms.

Case 9. Allergic conjunctivitis of both eyes in a 63-year-old female. All signs of inflammation and irritation in both eyes cleared completely in four days on cortisone drops 12 mg. per cc. given three times a day. This patient was seen three weeks later. The eyes had remained completely clear and symptomless.

Case 10. Forty-year-old female with a long history of recurrent allergic blepharitis with secondary keratitis and corneal scarring of both eyes. Following treatment with 12 mg. per cc. cortisone drops by instillation in both eyes all signs of irritation and inflammation disappeared leaving as sequel a moderate degree of corneal scarring of both eyes. This patient has been cleared too recently to determine whether or not recurrence will occur.

Case 11. Iritis in a 60-year-old male. A low-grade, chronic quiet iritis was first noted in the left eye three months following intracapsular cataract extraction. Despite atropinization and many other measures, including a lengthy period of hospitalization, this process continued for a period of one year and did not respond favorably to any form of therapy. Within two days after beginning instillation of cortisone drops 12 mg. per cc. every three hours, improvement was noted and after a period of four days there were no cells apparent on slit lamp examination for the first time in a period of one year. It is too early to determine whether or not there will be a recurrence.

Case 12. Thirty-two-year-old male with acute iritis of five days' duration in the left eye. There had been two previous attacks of iritis, one of which three years previously had been bilateral. His previous attacks of iritis had subsided slowly upon atropinization and typhoid vaccine therapy. In the present attack the eye became red and painful five days before the initiation of treatment in this office. Atropinization and cortisone drops every two hours, day and night, 12 mg. per cc. were given and in three days the eye had completely quieted. The patient was continued for one week on cortisone drops four times a day and there has been no recurrence.

Case 13. Fifty-seven-year-old female with pemphigus of both eyes of many years' duration. There was advanced shrinkage of the conjunctivae of both eyes. The left eye was blind and soft, the right eye had light perception with poor projection in all quadrants. Cortisone 25 mg. per cc. every two hours in the right eye was given. Little or no hope of improvement was entertained at this time. The patient, who came from a distant state, refused hospitalization or a course of treatment under observation here.

Three weeks later a letter was received from this patient requesting additional cortisone stating that there had been considerable improvement in the vision of the right eye. It is hoped that this patient will return at a later date and a complete report can be given.

A large number of additional patients with varied eye diseases have been treated with topical cortisone with favorable results but insufficient time has elapsed for a definitive clinical judgment of the final result.

COMMENT

1. However spectacular the action of topical cortisone, it is not a panacea for every eye disease.

2. Local heat, atropine and antibiotics are not replaced by cortisone but they should be used either alone or concurrently as indicated. Cortisone alters the cellular, tissue, humoral or vascular response of the organism or all four. It does not attack disease processes directly nor does it kill bacteria.

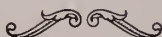
3. In a very general way, it may be said that the mechanism of action of cortisone lies in the prevention of the inflammatory response. It is obvious that this may be partially harmful to the reparative processes. Further study on this problem is indicated.

SUMMARY

1. Of thirteen patients with a variety of inflammatory and traumatic eye diseases who were treated with topical cortisone, not one failed to respond favorably to its administration.

2. The response to therapy was in some cases so immediate and so dramatic as to be almost incredible.

3. The ease, simplicity, low cost and absence of undesirable side effects are characteristic of topical instillation of cortisone.



Blastomycosis in Oregon

WILLIAM L. LEHMAN, M.D.,* and LEON F. RAY, M.D.
PORTLAND, ORE.

THIS brief case report is submitted to call attention to the development of a blastomycosis dermatitidis infection in an Oregonian. Physicians in the Pacific Northwest should keep this uncommon deep fungus disease in mind when treating multiple or single ulcerating skin lesions which do not respond to the usual therapeutic measures and antibiotics.

A 47-year-old white male was admitted to Good Samaritan Hospital, Portland, with boils, having been perfectly well until four weeks prior to admission. He had never been out of Oregon.

For two months prior to the present illness he had been working as a laborer weeding in an onion field within twenty-five miles of Portland, when he noticed a small, tender "kernel" in the left lower quadrant of the abdominal wall. It was extremely tender and grew to the size of a walnut, became fluctuant and drained a thick, bloody, purulent material. Shortly following this he developed similar lesions in the sternoclavicular region and left submaxillary area. These were lanced by his family physician, liberating considerable pus. Following this, he was treated in a local hospital, receiving sulfa drugs and penicillin but, in spite of therapy, he continued to develop multiple cutaneous lesions which broke down and drained a sanguineous purulent material. The patient thought he had had a low grade fever since the onset but there had been no chills or other systemic complaints.

Family history and past history were noncontributory except for an attack of lumbar pain in the summer of 1947 which radiated around to the front. No renal or bladder stones were found at this time, but later there had been some hematuria and dysuria.

Physical examination revealed about fifteen cutaneous lesions over the legs, arms, back, abdomen and neck which were in various stages of suppuration and ulceration. Several lesions presented draining sinuses and undermined ulcer edges. Several large tumor masses showed necrotic centers with fluctuation and induration of the periphery. All lesions were extremely tender. The remainder of the physical examination was essentially negative. No lymph nodes were palpable in any of the usual regions. A roentgenogram of the chest showed no evidence of pulmonary pathology. For several days following admission there was no change in the patient although he complained of moderate weakness. Shortly afterwards a biopsy of a lesion on the abdominal wall and lower left leg was done. The microscopic examination showed cutaneous abscess formation with considerable necrotic material as well as dense accumulations of granulocytes. The surrounding tissue contained many plasma cells as well as lymphocytes and other inflammatory mononuclear cells. Many histiocytes and scattered multinucleated giant cells were found.

Very careful examination under reduced light revealed yeast forms in the areas of purulency and in giant cells but no budding forms were found. These were interpreted as blastomyces dermatitidis. Guinea pig inoculation was negative, but an unmistakable culture of *Zymonema dermatitidis* grew on Sabouraud's media. Intradermal injection, 0.1 cc., 1-1000 *Zymonema dermatitidis* produced a 2 cm. red nodule in 48 hours.

Potassium iodide in a saturated solution was started after the diagnosis had been made, beginning with

5 drops t.i.d. and gradually increasing one drop per dose per day up to 20 drops t.i.d. Several days after administration of potassium iodide the lesions appeared to be improving and considerable healthy granulation tissue had developed. However, a secondary wound infection developed in the biopsy site and sulfa drugs and penicillin were started. He received in all 46 Gm. of sulfadiazine and 14 Gm. of sulfamerazine over a thirteen-day period with 3,900,000 units of penicillin intramuscularly. Vaccine therapy was not used.

A summary of the laboratory work showed a hemoglobin varying around 15 Gm. per hundred cc. (Sahli) with a white blood count of 16,600 on admission which gradually fell to 7,900. The neutrophils decreased concomitantly from 79 to 50 per cent over the same period. Several urinalyses were essentially negative. Sulfa levels increased from 10 to 14.8 mgms. per cent during the time of administration. The temperature throughout his entire stay was normal.

Four weeks after admission and three weeks after potassium iodide was started, the patient felt considerably improved and the drainage from the lesions had decreased. He was discharged on the above dosages of saturated solution of potassium iodide and followed as an outpatient. Roentgen therapy was given periodically to selected slowly healing areas and all lesions were healed within the following six months.

Blastomycosis is chiefly seen in the Middle West but cases have been reported in any section of the country. The incubation period is unknown but has been estimated to be one to two weeks. The causative organism is a fungus *Zymonema dermatitidis* (*Blastomyces dermatitidis*) which may have a saprophytic existence on plants. *Blastomyces* are widespread in nature. Cases have been reported following scratches, wounds and bruises from plants and are not uncommon among gardeners and allied occupations.

The disease may be local or systemic. Generally the initial lesion appears on the exposed surfaces of the upper extremities or face, but may occur anywhere. The tongue and lungs have been primary sites. The skin lesion is primarily a papulopustule which soon becomes crusted. A furunculoid lesion may develop as in this case, but generally with peripheral extension an elevated plaque is developed. Crusting is present in varying degree and beneath the crusts the surface is irregular papilliform and covered with a seropurulent secretion. The edge is smooth and slopes abruptly. On its surface minute abscesses may be seen and fluid

*Pathologist, Good Samaritan Hospital, Portland, Ore.

from them provides material for cultural identification of the fungus.

Systemic dissemination is not common but, when present, involves the lungs in 90 per cent of cases, early demonstrating symptoms of an acute respiratory infection and later suggestive of tuberculosis. The kidneys and bone may be involved, especially the ribs and vertebrae.

Therapy varies with the individual case. Saturated solution of potassium iodide, 5 to 15 or more drops three times daily, is valuable. Specific vaccine therapy is highly valued in chronic cases and should be instituted before iodide therapy. Roentgen therapy to selected lesions has stood the test of time. Surgery may be considered for small accessible lesions.

A Resolution

**Passed by American Association of Medical Record Librarians at Boston
October 24, 1950**

WHEREAS, the American Association of Medical Record Librarians believes that a voluntary health insurance program would more adequately serve the American public; and

WHEREAS, the American public has benefited by medicine as practiced under this voluntary insurance program; therefore

BE IT RESOLVED, that the American Association

of Medical Record Librarians does hereby go on record against any form of compulsory health insurance or any system of political medicine as provided for in Senate Bill 1679.

MARGUERITE E. HOOVLER

CLARA SCHWABE

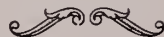
DORIS GLEASON, *Chairman*

Resolution Committee

Public Health Committee

The Washington State Veterinary Medical Association at a recent meeting formed a public health committee for the purpose of cooperating in planning and initiating veterinary aspects of programs directed at preventing transmission of animal diseases to man. The committee consists of Drs. J. C. Kraft, Seattle; R. H. Bradbury, Mount Vernon; D. E. Ferguson, Pasco; R. R. Weller, Tacoma, and

Myles Van Hoosen, Pullman, who will work through Dr. M. A. Holmes, Veterinary Public Health Consultant of the State Department of Health. Such programs as develop will be in cooperation with the State Department of Agriculture, School of Veterinary Medicine of Washington State College, private veterinarians and other agencies.





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Halpin, L. J.: An Appraisal of Therapeutic Procedures in Bronchial Asthma, J. Iowa M. Soc. 39:468 (Oct.) 1949.

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STATE SECTIONS

**OREGON STATE
MEDICAL SOCIETY**



**ANNUAL MEETING
1951**

President, W. J. Weese, M.D., Ontario

Secretary, R. F. Miller, M.D., Portland

Executive Secretary, Mr. C. C. Foley, Portland

Opinions, Views or Comments presented in articles appearing in this section are those of the individual authors and are not necessarily those of Oregon State Medical Society.

Medical Notes

Oregon Medical Education Resolution Approved

The resolution drafted by Dr. E. H. McLean, Oregon's senior A. M. A. delegate, instructing the A. M. A. Board of Trustees to make a study of the financial needs of medical schools and the possibility of the nation's doctors establishing some form of aid to them, was introduced at the Cleveland meeting of the A. M. A. House of Delegates. It was referred to the reference committee on Medical Education and Hospitals and, when this committee reported favorably, the resolution was adopted by the House without dissenting vote.

Whether or not the introduction of this resolution had anything to do with the matter, it so happened that the following morning the Board of Trustees made its dramatic announcement of the allocation of \$500,000 to the medical schools of the nation. Coincidence or not, the outstanding fact is that once more the Oregon State Medical Society demonstrated its thinking is "up front" in matters concerning medical stability and progress.

The matter is likely to receive further impetus at the Atlantic City meeting of the A.M.A. next June.

Blue Shield Insurance Company Ready to Go

At a meeting of the Blue Shield Commission held in Cleveland on December 2, 1950, it was announced that the capital stock of \$375,000 necessary to start operations had been subscribed by the prepaid medical care plans to the Blue Shield Insurance venture and that articles of incorporation would be filed with the insurance commissioner of the state of Ohio during December.

This is the controversial insurance company originally designed to form a companion venture to the Blue Cross' "Group Health Incorporated", a New York corporation, in the writing of one-package contracts with "national" accounts. Group Health, Inc., has already been launched and is empowered to underwrite both medical and hospital risks, according to communication from the Blue Shield commission. Since this is a departure from the original plans drafted for "joint" operation; there is now a doubt developing

among the Blue Shielders that they should proceed with their own insurance company launching. The company is being incorporated, however, but if it will proceed beyond this point will probably be determined by the manner in which the Blue Cross "Group Health Incorporated" conducts itself.

The Blue Shield Insurance Company claims it will operate only in the national accounts field or in those regions not now adequately covered by medical care plans.

Reorganization Recommended

The Blue Shield Association's committee on reorganization and structure held its second meeting prior to the A. M. A. convention in Cleveland and recommended a change in the composition and selection of the Blue Shield Commission, conducting the affairs of the association between annual meetings. At present the commission is composed of physicians and an administrator from each of twelve districts (the Pacific states form District XI) plus a number of commissioners at large.

Under the proposed change, which will be recommended to the annual convention of the prepaid medical care plans in April, the commission will consist of a total of twenty-one individuals, all of whom must be doctor trustee members of local plans and be or have been practicing physicians. These commissioners will be selected in such a manner that they will serve three-year terms, with seven positions filled each year. Selection on a regional or geographic basis will be continued but without reference to the present "district" arrangements. To facilitate selection the commission will nominate three persons for each vacancy and the member plans will nominate two additionally if they wish. From these five nominees one commissioner for each vacancy will be elected by the vote of the plans in annual meeting.

To aid the all-doctor policy-making commissioners, an advisory board of administrators and technical assistants has been recommended, the selection of this purely advisory board to be made by the commission itself.

Other recommendations are contemplated, involving changes in the method of voting and in basic policies. At present these are receiving further study.

Should the recommendations of the committee be adopted by the annual meeting of the Blue Shield plans next April, they will not become effective until 1952 unless the present commissioners choose to resign and permit their successors to be selected in the newly recommended manner.

O. P. S. Pools Start New Late Billing Discounts

Although some pools in O. P. S. have followed for some time the practice of discounting physicians' bills which are filed late, the size of the discounts applied has not been uniform. At the annual trustees' meeting in Gearhart, the O. P. S. directors authorized an extension of the practice throughout the state on a uniform basis, subject to the desire of local pools to avail themselves of the practice.

The following letter, sent to physicians in the Portland area by the Multnomah County supervisory committee, outlines the provisions and is typical of letters sent out by a number of other pools which have decided to use discounts to discourage late filing of bills.

Dear Doctor:

Late billing for doctor services creates a problem wherein it is extremely difficult to determine the financial status of the pool at any given time since it is not known what financial obligations have been incurred but not reported. It also increases the clerical expense of processing the bills which in turn affects the pool's financial experience adversely.

The rules for billing O. P. S. were set up to avoid a situation of this kind. They provide that doctor bills should be in the proper O. P. S. office by the tenth of the month following service. (See Page 21 of the O. P. S. Schedule and Handbook.)

For some time late bills have been discounted, but recently the O. P. S. Board of Directors was asked to establish a statewide schedule to be available to the various O. P. S. "pools" for discounting delinquent doctor bills on a uniform basis. The following schedule was provided by the board and was adopted by your Supervisory Committee at its November meeting:

1. 10 per cent discount after 60 days' delinquency.
2. An additional 10 per cent discount for each additional month of delinquency.
3. Proper consideration to be given cases of delinquent billing involving extenuating circumstances.

Beginning with December services the Business Office has been instructed to apply this schedule, instead of the discount schedule formerly used in Multnomah County. We thought it best that each physician in the Multnomah County Pool be made aware of this change.

Very truly yours,

OREGON PHYSICIANS' SERVICE SUPERVISORY
COMMITTEE FOR MULTNOMAH COUNTY

Support Is Where You Find It

Some weeks ago a physician from Eastern Oregon had occasion to make a fraternal (read convivial if you insist) visit to a Portland colleague to whom he occasionally refers cases.

As the evening progressed the conversation turned, as it does so many times these days, to the subject of

doctor and hospital relations. The big city doctor stood up for the hospitals, claiming they supported the medical profession in every way, would grant any reasonable request from doctors, and so forth. The doctor from east of the Cascades had a different idea about it.

As the argument waxed with increased vigor the Portland consultant challenged his colleague to cite just one instance where hospitals were not backing up the medical profession. The upstater accepted the challenge, cited the matter of hospitals displaying O. P. S. and Blue Cross literature and the rhubarb was on more furiously than ever, the city doctor claiming hospitals displayed *both* kits, while the trans-Cascader insisted just as vehemently only the Blue Cross display kit got the play.

Midnight having arrived without any agreement being reached, the cohorts resolved to settle the point by making the rounds of the Portland hospitals for first-hand information. The score: Blue Cross 7; O. P. S. 0.

The next day, intrigued by the experience of the previous evening, the colleagues started some inquiries about the state generally. Result of the survey: O. P. S. publicity packages known to be displayed in four hospitals.

NOTE: A query to O. P. S. revealed the doctors' own sponsored plan had not made an issue of hospitals displaying O. P. S. publicity kits, felt it was useless to request hospitals to do so in competition with their own Blue Cross organization after the experience suffered by one O. P. S. executive, who personally placed O. P. S. publicity kits in six hospitals, found four of these removed at a subsequent visit two weeks later.—Ed.

Pete the Pest Says:

Rainy Day? Several Oregon medicos profess to see touch of humor in bill received from attorneys defending Oregon State Medical Society in government antitrust suit. Seems amount of bill corresponded exactly with fund established long ago against possible rainy day. Docs are wondering if selection of exact amount by attorneys was one of those coincidental things or if maybe they figured being law-sued by Uncle Sam added up to rainy day.

Cooling off: Visitors to recent A.M.A. convention at Cleveland noted absence of controversy which featured some other meetings. Generally attributed to fact doctors are waking up to ultimate issues at stake and are pretty well agreed what they have to do, leaving major discussions only on how to do it, not usually too controversial. Wise guy cracked: "Some A.M.A. headaches were cured by voters on November 7. Let's have another election while people are in the same mood!"

WASHINGTON STATE MEDICAL ASSOCIATION



ANNUAL MEETING SEATTLE, 1951

President, K. L. Partlow, M.D., Olympia

Secretary, J. W. Haviland, M.D., Seattle

Executive Secretary, Mr. R. W. Neill, Seattle

Medical Notes

MEDICAL SCHOOL RECEIVES GRANTS. Two grants totaling \$58,536 have been announced by the United States Public Health Service for cancer research by the University of Washington School of Medicine. Stuart Lippincott, executive officer of the school's department of pathology, said one grant of \$48,500 was for his department. The remainder was granted to the department of obstetrics and gynecology.

STATE HEALTH GROUPS FORM NEW COUNCIL. Washington doctors, dentists, nurses and other professional health workers have banded with government and voluntary agencies to form a new State Health Council. C. E. Watts, Seattle, president of the Council, said the new group's objectives are to study health problems in the state, make recommendations as to the proper solutions and to attempt to put the findings into effect.

CHEHALIS DOCTOR NAMED TO STATE MEDICAL BOARD. Governor Langlie appointed William D. Turner, Chehalis, to the state board of medical examiners on November 24. He will fill the vacancy created by the resignation of Thomas Reed Ingham.

U. OF W. RENAMED IN INFLUENZA STUDY. Reappointment of a unit of the University of Washington School of Medicine as a collaborating agency of the World Health Organization was announced recently. For the third year, the university's virus research laboratory of the Department of Public Health and Preventive Medicine will aid in the worldwide fight against influenza. This is being sponsored by W. H. O., a United Nations group. A network of agencies in all parts of the world reports outbreaks of influenza and the type of virus involved. The university laboratory will report directly to the Influenza Information Center in Washington, D. C. This agency reports to the W. H. O. headquarters in London.

MEDICAL LICENSE TESTS IN JANUARY. The State Department of Licenses announced December 16 that tests for persons seeking state medical licenses will be given at the University of Washington January 22-24. Osteopathy, chiropractic and drugless examinations will also be held on the same dates. Basic science examinations will be given January 17-18.

H. L. Hartley, assistant editor of *NORTHWEST MEDICINE*, attended the January 13 meeting of the publication committee of GP, official publication for the American Academy of General Practice. Arthur N. Jay, Indianapolis, is chairman of the committee of three which also includes Stanley R. Truman, Oakland, and Hartley, Seattle.

This group is a working committee as well as an advisory committee. The members are expected to do occasional editorials, write book reviews and take an active part in publishing GP. Mr. Mac F. Cahal, executive secretary of the Academy, is managing publisher. Editor is Walter C. Alvarez, Mayo Clinic, Rochester, Minn. First launched in 1950, GP is considered to be one of the most outstanding medical journals published in this country.

Locations

WILLIAM J. SINCLAIR has joined E. B. Coulter and H. E. Wheeler, Fernwell Building, Spokane, in the practice of general surgery. He is a graduate of the University of Manitoba Medical School and completed his internship at St. Boniface Hospital, Winnipeg. His residencies include six months in neuropsychiatry at the University of Toronto Hospital and two years in neurosurgery at McGill University Hospital.

MERTON SHELTON moved to new offices in North Bend on November 15. He is a graduate of Walla Walla College and the College of Medical Evangelists in Los Angeles. He interned at Seattle General Hospital and the Doctors Hospital, and has been practicing in Seattle for the past five years.

AUGUST JANSONS has been added to the staff of the Northern State Hospital near Sedro-Woolley. He is a specialist in neurology and his appointment to Northern State affords the institution its first neurology specialist. He is a graduate of the University of Latvia and has had considerable practice in European centers.

Hospital News

DEACONESS HOSPITAL, Spokane. The regular monthly meeting of the medical staff was held at the hospital November 14. It was voted to institute a Consultative Tumor Board under the direction of Ted E. Ludden, pathologist. Norman C. Trauba, superintendent of the Veterans Hospital, explained the eligibility of veterans for hospital care. Hugh S. Brown presented a review of the differential diagnosis and treatment of peripheral vascular diseases. The recognition of chronic occlusive arterial disease, such as arteriosclerosis obliterans, thromboangiitis obliterans and functional vascular diseases like Raynaud's disease, were discussed. Performance of a complete vascular examination was urged for persons suspected of having vascular disease and inclusion of a cursory peripheral vascular examination in the course of a complete physical examination.

YAKIMA VALLEY MEMORIAL HOSPITAL. Mrs. Nancy McClure Karnoven has been named chief medical technologist at Yakima Valley Memorial Hospital. She is the daughter of Mrs. W. L. McClure and the late Dr. McClure. Before returning to Yakima she was a serologist at the Seattle blood bank.

SEATTLE VETERANS ADMINISTRATION HOSPITAL. Don E. Nolan, chief of professional services at the Dayton, Ohio, Veterans Administration center, has been appointed manager of the 325-bed Veterans Hospital in Seattle. Dr. Nolan has been with the V. A. since 1938. The hospital, now nearing completion, is expected to receive its first patients in April.

PINEL FOUNDATION. A second guild for assistance to Pinel Foundation, Seattle's nonprofit hospital for treatment of mental illness, has been organized and the first meeting of the group was held recently at the home of Mrs. Leo Shulman. Miss Garland K. Lewis, director of nursing for the foundation, spoke at the meeting. A former Menninger clinic staff supervisor, Miss Lewis trained navy corpsmen in psychiatric nursing at Great Lakes Naval Training Station for four years and was also in charge of a psychiatric unit at Bethesda Naval Hospital.

KADLEC HOSPITAL, Richland. Physical therapy will be available at Kadlec Hospital for pupils enrolled in the Orthopedic room special education program established recently for physically handicapped children. The orthopedic room is under the administration of the Richland public schools, assisted by the Richland public health and welfare division. The unit is sponsored by the State Department of Health.

ST. ELIZABETH HOSPITAL, Yakima. Seventy doctors turned out for the annual St. Elizabeth Hospital staff dinner held in November at the school of nursing. This was the largest turnout in the history of the annual event, James P. Thompson, retiring president of the hospital staff, said. All Yakima doctors, with the exception of three who were out of town, were in attendance. At election of officers, Frank LeFor was named president, succeeding J. P. Thompson. Leland Harris was named to succeed William F. Sims as vice-president and Guy Marcy succeeds John Skinner as secretary-treasurer.

HOSPITAL DISTRICTS OF STATE OF WASHINGTON. Mr. J. C. Lund, administrator of the Renton Hospital, was elected president of the newly organized Association of Hospital Districts of the State of Washington. The association was organized recently at a meeting of hospital district representatives in Ellensburg. Lund attended from Renton with Elmo Wright, chairman of the board of commissioners. At the present time there are 14 hospital districts in the state and more are being added.

HOSPITALS RECEIVE CANCER FUNDS. Seven Seattle hospitals and Renton General Hospital recently received grants totaling \$7,900 from the Washington division, American Cancer Society, for care of cancer patients who cannot afford to pay. Seattle hospitals receiving the grants are Swedish, Providence, Seattle General, Virginia Mason, Columbus, Doctors and Maynard. The division's executive committee also voted to continue

payments to the Seattle Visiting Nurse Association for calls on cancer patients.

Society Meetings

CLARK COUNTY MEDICAL SOCIETY. The regular meeting was held at the Royal Oaks Country Club, December 5. Following dinner and social hour a film on *The Use of Curare in the Treatment of Polio* was shown. The application of John Harrah was read and referred to the Ethics Committee. He was previously a member of King County Medical Society and requested transfer to Clark County. The annual election of officers for 1951 was held and the following were elected: David R. Loree, president; E. A. Underwood, vice-president; Frank Butler, secretary; Dennis Seacat, treasurer; Asa Seeds and David Loree, delegates, and Leslie Nunn and Karl Stefan, alternate delegates.

CLALLAM COUNTY MEDICAL SOCIETY. Regular meeting was held at the Port Angeles General Hospital, November 20. Suretz Carlson and Andrew Laico were approved for admittance into the society. Quintin Kintner, president, reported on the drafting of physicians and dentists. He stated that if a county society appointed a committee within their county, the local draft board would be obligated to consult with this committee prior to drafting any physician or dentist. He appointed the following committee: J. L. McFadden, chairman; R. S. Hamilton and I. E. Kaveney. The secretary was instructed to notify the local draft board of such a committee. Following the business meeting, Dr. Hamilton presented a paper on *The Use of Cortisone and ACTH*.

THURSTON-MASON COUNTIES SOCIETY. The group met at the Olympia Country Club, November 28. C. E. McArthur presented a paper on *The Common Pitfalls of Fractures*. Roger Anderson elaborated and emphasized certain points of this paper and then gave a talk on *The Diagnosis and Treatment of Backache*. This was the annual meeting and the election of officers was included in the business session.

WALLA WALLA VALLEY MEDICAL SOCIETY. B. E. McConville, Seattle, was featured speaker at a meeting held at Walla Walla, November 9. His subject was *The Treatment of the More Common Fractures*.

COWLITZ COUNTY SOCIETY. Herbert A. Minthorn took office as president of the society for 1951 at the group's meeting in the Monticello Hotel, Longview, November 15. John Nelson was named to attend the state convention as the group's delegate next year. Ed Davis, neurosurgeon, gave a talk on the surgical approach to high blood pressure, reporting that many selected cases have responded very well to a newly developed surgical treatment.

YAKIMA COUNTY MEDICAL SOCIETY. At a dinner meeting of the society, held on November 13, H. S. McGuinness was honored as the outstanding general practitioner for Yakima County in 1950. Kenneth M. McCoy, president of the society, announced the selection. McGuinness began practice in Yakima in 1923 and for several years served as county doctor. He practiced in Wisconsin before coming to Yakima.

KING COUNTY SOCIETY. David Metheny was elected president of the King County Medical Society at a

meeting December 4 in the auditorium of the Health Sciences Building at the University of Washington, Seattle. David Metheny succeeds Ralph H. Loe. Clark C. Goss was chosen president-elect and Frederick A. Tucker was named secretary-treasurer. John S. Lingenfelter, John H. Culp and Ralph Loe were elected trustees.

SPOKANE ACADEMY OF GENERAL PRACTICE. R. Mac O'Brien was elected president of the Academy at a meeting held November 26 at Sacred Heart Hospital. Other officers elected were Fred Harvey, vice-president; Bert Jacobson, secretary-treasurer, and F. E. Bertling, A. A. Sallquist and E. F. Parker, trustees. Dr. Harriet Judy talked on experimental findings and cortical hormone treatment of chronically fatigued women.

Woman's Auxiliary

KITSAP COUNTY UNIT. Plans for the year's work on a county, state and national basis were discussed by Mrs. R. M. Schulte of Spokane, president of the Woman's Auxiliary to the Washington State Medical Association at a recent meeting of Kitsap County unit at the home of Mrs. John Schutt, Bremerton. More definite participation in community projects was urged by Mrs. Schulte who declared that doctors' wives were inclined to be both modest and lax where local activities are concerned. Mrs. Albert J. Bowles, Seattle, president-elect of the state auxiliary, discussed the Bulletin, official handbook published by the auxiliary to the American Medical Association, and the health magazine, *Today's Health*.

HARBOR MEDICAL AUXILIARY. The new officers of the Washington State Woman's Auxiliary were honored at a dinner November 15 at the home of Mrs. Arthur Skarperud, Aberdeen. Assisting the hostess were the Mesdames F. N. Berken, Kenneth D. Graham and M. P. Graham. Mrs. H. I. Weiner and Mrs. M. F. Fuller reported on the A.M.A. convention held in San Francisco and also on the state meeting held in Spokane. Mrs. Skarperud presented an outline of the program for the year.

COWLITZ COUNTY GROUP. Mrs. C. W. Spellman, Kelso, played hostess to members of the Woman's Auxiliary to the Cowlitz County Medical Society recently. Dr. Spellman showed a movie, "The Howards of Virginia," to the group. Refreshments were served by Mrs. Spellman and the assistant hostess, Mrs. H. D. Feusner.

WALLA WALLA VALLEY AUXILIARY. Featuring the program for the Woman's Auxiliary to the Walla Walla Valley Medical Society held at Walla Walla, November 9, was a talk by Mrs. Elinor Croft on flower arrangement. Hostess was Mrs. Ralph Keyes. Mrs. Wallace A. Pratt gave a demonstration of charcoal sketching. Eighteen members shared the potluck dinner and program.

Obituaries

DR. LOUIS H. KLEMPNER, 85, Seattle, died December 7. Believed to be one of the oldest practicing physicians in Seattle, he was born in Rego, Latvia. He studied at the University of Dorpat in Latvia. An

eye, ear and nose specialist, he took additional studies in his specialty in Berlin and Vienna. He came to this country in 1904 and to Seattle in 1907. Dr. Klemptner was a member of the American College of Surgeons, the Pacific Coast and Puget Sound Academy of Ophthalmology and Otolaryngology and the American Medical Association. He was an honorary member of the King County Medical Society.

DR. JOHN WHEELER SCHORI, 50, Bellevue, died suddenly December 6 at his home in Medina. Born in Elmwood, Ill., he was a graduate of the University of Illinois School of Medicine. He practiced medicine at Spirit Lake, Idaho, before moving to Bellevue 15 years ago. He was a member of the American Academy of General Practice and Washington State Obstetrical and Gynecological Association.

DR. MARION GOLDIE YOUNG, 81, Seattle, died November 19 at her home. She received her medical degree from New York Medical College and Hospital for Women, 1916. She was a parliamentarian and organizing regent of the Sarah Buchanan Chapter of the Daughters of the American Revolution.

DR. ARTHUR FULTON WARREN, 53, Longview, died after a heart attack at his home, November 25. He was a graduate of Stanford University School of Medicine, 1923, and came to Washington in 1949 after practicing medicine in New York for thirteen years and spending five years in the service in Europe and the Pacific. Specializing in eye, ear, nose and throat practice, he moved to Longview from Aberdeen in April, 1950.

DR. HERMAN TRAGER, 64, Seattle, a Veterans Administration physician, collapsed and died at the University of Washington School of Medicine November 28. Born in Russia, Dr. Trager came to this country sixty years ago. He was a graduate of the University of Pennsylvania Medical School. Before coming to Seattle four years ago, he had practiced medicine in Philadelphia and had been with that city's Health Bureau twenty-five years.

DR. FRANCIS W. ANDERSON, 73, South Bend, died November 20. He received his degree from University of Minnesota Medical School in 1911 and came to Washington the following year. A member of the American Medical Association, he served in France during World War I with the Army Medical Corps with the rank of major.

DR. RALPH HENDRICKS, 76, Spokane, died November 15, following a heart attack. He received his medical degree from the University of Louisville School of Medicine, Kentucky, in 1906, and came to Washington in 1908. He served as city health officer in Spokane for many years and had been serving more recently as a screening physician for the Spokane county welfare department. He was a member of the American Medical Association and was a Spokane city commissioner from 1923 until 1947.

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President Henry G. Shaw Reports On American Surgical Trade Association Meeting

The American Surgical Trade Association, at its midyear meeting held in the Waldorf-Astoria Hotel, New York, December 11, 12 and 13, considered the planning by the Federal Civilian Defense Administration for protection of the population from atomic

bombing and for stockpiling of essential surgical equipment and supplies near strategic targets in preparation for such an emergency, reports Henry G. Shaw, president of the association.

The American Surgical Trade Association is a national association of about 450 distributors and manufacturers of surgical equipment and supplies comprising nearly 85 per cent of the industry in the U. S. A.

Mr. Shaw, who has been identified with the surgical supply business

in the Pacific Northwest for over 50 years, was honored by election to the presidency of the American Surgical Trade Association in June, 1950, succeeding Harry H. Carnahan of Huntington, West Virginia. His election is the first time in over 30 years that a member from west of the Rockies has received this high honor.

Born in Michigan, Mr. Shaw came west with his parents in 1895, residing in Tacoma. He was appointed manager of the first exclusive surgical supply house in Washington located at Spokane about the turn of the century and in 1906 with his brother, Paul T. Shaw, founded his own business in Tacoma, later establishing stores in Seattle and Portland. The Seattle store is managed by his son, Thornton K. Shaw.

Mr. and Mrs. Shaw enjoyed a brief holiday in Bermuda following the meeting, returning home after spending Christmas with their daughter and son-in-law (Dr. Ted Haley) and family in New York.

Representatives of the Washington State Medical Bureau and the State Department of Health have met several times during the last two weeks in the process of negotiating a contract under which the two agencies can function under the newly enacted Initiative 178 which becomes effective February 1.

In the meantime, King County Medical Service Bureau has effected a working agreement wherein it will operate differently under a special contract that takes cognizance of the King County Hospital and the University of Washington School of Medicine.



HENRY G. SHAW

Barnes Joins Staff

Howard L. Barnes, well-known Seattle public relations man, has been added to the staff of the Washington State Medical Association, central offices at White-Henry-Stuart Building, Seattle.

Barnes will be assistant to Executive Secretary Ralph W. Neill and at the same time will be largely responsible for a greatly broadened public relations

program as recommended by the Association's public relations committee.

Announcement of Barnes appointment comes from State Association President Dr. K. L. Partlow, who states that the new program, as approved by the Executive Committee at its December meeting, calls for cooperative integration of the work of the grievance, professional and public relations committees.

"Additional emphasis will be placed on increasing and broadening

voluntary medical prepayment programs; improving inter-professional relationships; improving emergency call programs; increasing consultation with the county societies and auxiliaries throughout the state and expanding information service to newspapers, radio and other media," Dr. Partlow states.

Mr. Barnes, who was formerly manager of the Manufacturers' Association of Washington, has had a long experience with metropolitan newspapers in Seattle and New York. He is specialized in public and governmental relations work.

As one of his first assignments, Barnes will assist Executive Secretary Ralph W. Neill at Olympia during the forthcoming session of the state legislature.



HOWARD L. BARNES

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Administration of Medical Care Program

Local administration is the central theme in preparation of medical care plans for Washington's indigent and medically indigent under Initiative 178 which transferred the public assistance medical care program from the State Department of Social Security to the State Health Department.

As a code department, the State Health Department, under the direction of the State Director of Health, is responsible for administering and enforcing state health laws and the rules and regulations of the State Board of Health. The State Board of Health is a five-man board appointed by the Governor to advise and assist the State Health Department and to make rules and regulations.

The State Board of Health, with the counsel of members of the medical profession and others, will lay down broad policies and regulations. These will be worked out in detail, adapted to fit varying local needs and administered by local health departments in cooperation with physicians, dentists, hospitals and other vendors of service.

An advisory committee of the Washington State Medical Association is working with the State Board of Health and a Council of Medical Service created by Initiative 178 and will study and make recommendations on the overall program as well as carry on an educational program.

The State Health Department became responsible for the medical care program on December 7, 1950, but the Department of Social Security continued to handle it as agent of the Health Department during an interim period while arrangements were made for the change. By February 1, 1951, state and local health departments are expected to be in full charge of the program. In the meantime, rules and regulations of the Department of Social Security are being kept in effect.

Initiative 178 was passed by the state's voters with the aim of cutting down the high costs of welfare and the medical program under Initiative 172. Public assistance medical care is now based on need, whereas under Initiative 172 it was based on the desires of the recipients. The new law, it is hoped, will eliminate chiselers among both recipients and vendors. It is expected to save taxpayers seven million dollars in the next two years.

While local health departments will be primarily charged with administering the new medical care program, its success will be largely in the hands of hometown physicians. This is because the determination of what is necessary and what is unnecessary is up to them. Furthermore, cooperation will be needed between health departments and local medical societies in setting up possible prepaid medical plans, fee schedules, methods of control and administration.

J. A. KAHL,

Acting State Director of Health

IDAHO STATE MEDICAL ASSOCIATION



ANNUAL MEETING JUNE 17-20, 1951 SUN VALLEY

President, R. T. Scott, M.D., Lewiston

Secretary, R. S. McKeon, M.D., Boise

Executive Secretary, Mr. A. L. Bird, Boise

Medical Notes

Society Meetings

IDAHO FALLS MEDICAL SOCIETY. David H. Smith was elected president of the Idaho Falls Society at a dinner meeting at the Bonneville Hotel December 1. Having served as vice-president of the organization during the past two years, he succeeds N. H. Battles. Other officers elected were Dauchy Migel, vice-president and H. R. Fishback, reelected secretary. Delegates to the Idaho State Medical Association meeting for a two-year term were Milton Rees and Hoyt B. Woolley, with alternates Wendell Neilson and Harry Willson. Franklin West, anesthesiologist, formerly of Salt Lake City, Utah, was elected to membership. Other business included a review of the medical clinic held in Idaho Falls during the past month.

SOUTHEASTERN IDAHO MEDICAL SOCIETY. New officers are Ralph B. Hegsted, president; Corwin E. Groom, president-elect, and Melvin M. Graves, secretary-treasurer. The election was held December 6 at the annual ladies' night and dinner at the Bannock Hotel. Plans were discussed for another scientific clinical conference in September, 1951, similar to the one held in September, 1949.

Locations

Sanford Allen, former resident physician of the State School and Colony in Nampa, has opened medical offices in the beauty shop building in Marsing.

Seven physicians have moved to their new clinic at 222 East Logan Street, Caldwell. These include G. W. and Leslie Montgomery, D. R. Peterson, C. M. Kaley, Charles Kerrick, S. D. Simpson and Lester Shupe.

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Seattle Boy Distinguished Against Socialized Medicine

One of the most healthy and encouraging incidents at the A.M.A.'s Cleveland session last month was a speech delivered by Peter E. Terzech for William L. Hutcheson, president of the United Brotherhood of Carpenters and Joiners of America, an organization of 700,000 A. F. of L. workers which is on record against socialized medicine. Terzech is a former Seattle boy and attended the University of Washington. He spent an evening, after delivering his boss' speech, with Washington State doctors, reminiscing about the Puget Sound country, and proved himself a thoroughly fine fellow.

Hutcheson's speech was full of pithy remarks, typical labor wit, and was loaded with sound, timely warnings to labor leaders everywhere. Terzech delivered the speech with appropriate emphasis and was given a standing ovation by the doctors. The speech was broadcast and should do a magnificent job in assisting the medical profession's campaign against socialism. Labor everywhere should take heed.

It would be useless to attempt an improvement by rewriting Hutcheson's paper, and it is too bad we can not give you Terzech's delivery. The following excerpts, however, will convey the principal thought expressed:

"Socialization and death have one thing in common. You can't be either a little bit socialized or a little bit dead.

"It will be a sad day for carpenters if the day ever comes when Uncle Sam usurps the power to dictate to doctors. If it is logical to nationalize the medical profession to get more medical service for the poor, it is equally logical to nationalize the home construction industry.

"I don't know much about doctors but I do know quite a bit about carpenters. They are an independent lot. They want to work where and how they please. The first bureaucrat who told a carpenter he had to work in Little Park when he wanted to work in Lancaster would be gumming his food for lack of peace.

"Carpenters want to be free agents. They will retain their freedom only so long as other groups retain theirs. Socialization of medicine would only be the first bite out of our free enterprise system. It would not be many years before the carpenters would be feeling the teeth of socialization on the seat of their overalls."

As one example of how socialized medicine works, Hutcheson compared the uneven distribution of doctors in London under socialized medicine, where the poorer districts have twice the patients of the wealthier districts. The speaker then gave this conclusion:

"If that isn't the one horse and one rabbit recipe transferred from the meat-pie-maker's kitchen to the national health program, then I need new reading glasses. I have tried to figure it out from all angles, but the answer I always come up with is that the lumbago, shingles and bellyache of London's South Siders get only half the attention under socialized medicine that similar complaints get in swankier districts.

"Any way you look at it, socialized medicine is no bargain and the carpenters want none of it."

The A.M.A. pulled a daily newspaper surprise on the doctors in Cleveland on the day of the coordinating committee's program and announced after the meeting that *The Journal*, which was available at the convention doorways, contained all speeches of that day's program. These speeches are in *The Journal* of December 9 and every word of the above quoted speech should be read by every doctor in Washington State and called to the attention of the leaders of every labor union.

Announcements of Medical Meetings

Eleventh Annual Postgraduate Convention, Oregon Academy of Ophthalmology and Otolaryngology

The convention will be held in Portland the week of March 25-30. Ophthalmology sessions are scheduled on March 26, 27 and the morning of March 28. The afternoon of March 28 and March 29 and 30 will be devoted to otolaryngology sessions. The guest speakers are R. Scobee, professor ophthalmology, Washington University Medical School, St. Louis; Bruce Fralick, professor ophthalmology, University of Michigan Medical School, Ann Arbor; Theodore Walsh, professor otolaryngology, Washington University Medical School, St. Louis, and Maurice H. Cottle, professor otolaryngology, Chicago Medical School, Chicago. Dr. Fralick will deliver the second annual John E. Weeks Memorial Lecture in ophthalmology.

Portland Surgical Society

The annual meeting of Portland Surgical Society has been scheduled for March 9 and 10. Alton Ochsner,

professor of surgery, Department of Surgery, Tulane University of Louisiana, will be guest speaker. Further details will be announced later.

Third Annual Midwinter Radiological Conference

The conference will be held at the Biltmore Hotel, Los Angeles, February 24-25. Nonradiological colleagues interested in any of the courses are also invited to attend. The cost for the entire two-day session is \$15. A banquet will be held on Saturday evening, February 25, at which the guest speaker will be Edward Chamberlain, professor and chairman of the Department of Radiology, Temple University, Philadelphia. Another featured speaker will be Edward B. D. Neuhauser, Roentgenologist, Infants and Children's Hospital, Boston, Mass. The fee for the banquet will be \$5. Reservations for the conference and banquet should be accompanied by a check for \$20 and sent to Dr. John B. Hamilton, 210 North Central Avenue, Glendale 3, California.



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*Diefenbach, W. C.,
and Meneely, J. K., Jr.:
Yale J. Biol. & Med.
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(1) Schweigert B. S.: Significance of Vitamin B₁₂ and Related Factors, J. Am. Dietetic Assoc. 26:782 (Oct.) 1950.

(2) Lewis, U. J.; Register, U. D.; Thompson, H. T., and Elvehjem, C. A.: Distribution of Vitamin B₁₂ in Natural Materials, Proc. Soc. Exper. Biol. & Med. 72:479 (Nov.) 1949.

(3) Shorb, M. S.: Activity of Vitamin B₁₂ for the Growth of *Lactobacillus lactis*, Science 107:397 (Apr. 16) 1948.

(4) Hartman, A. M.; Dryden, L. P., and Cary, C. A.: The Role and Sources of Vitamin B₁₂, J. Am. Dietetic Assoc. 25:929 (Nov.) 1949.

(5) Frost, D. V.; Fricke, H. H., and Spruth, H. C.: Rat Growth Assay for Vitamin B₁₂, Proc. Soc. Exper. Biol. & Med. 72:102 (Oct.) 1949.

(6) Wetzel, N. C.; Fargo, W. C.; Smith, I. H., and Helikson, J.: Growth Failure in School Children as Associated with Vitamin B₁₂ Deficiency—Response to Oral Therapy, Science 110:651 (Dec. 16) 1949.

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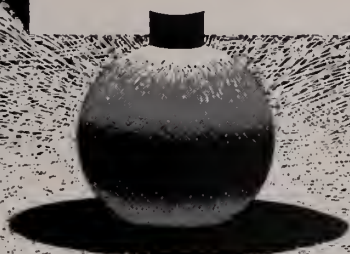
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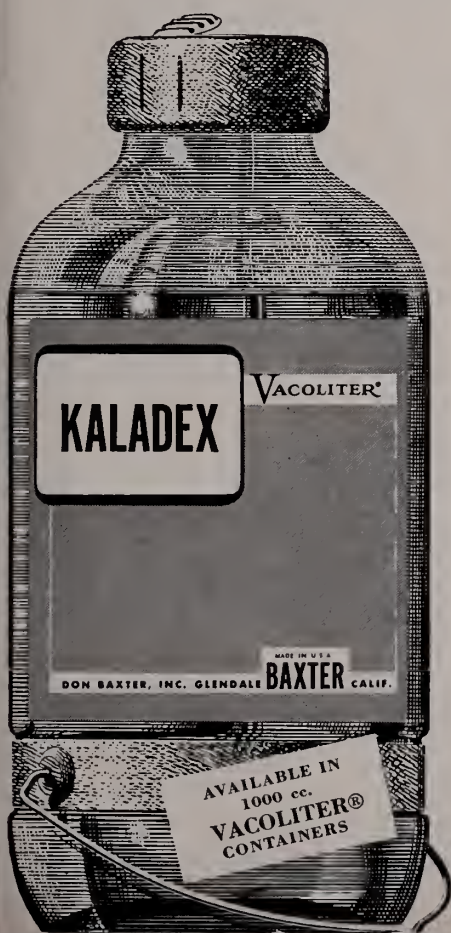


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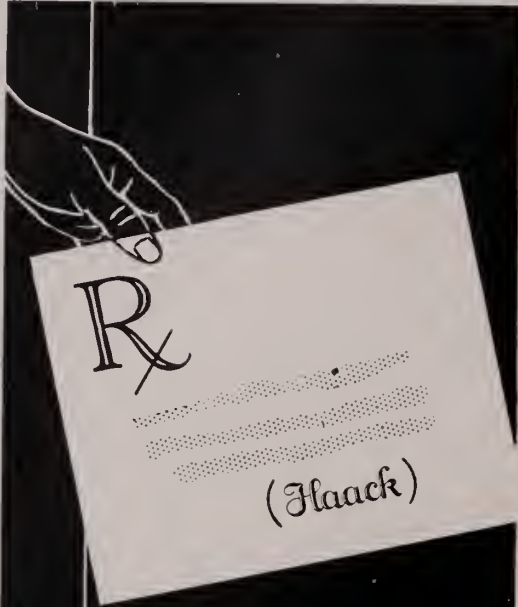
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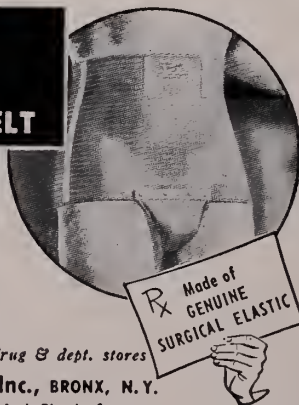
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*Valter & Dollfus: Bulletin Societe d'Ophthalmologie of Paris, Jan. 21, 1950.
 Mussia-Fournier; O. Conti and I. Porta: Ann. d'Endocrinol, Paris, 1947.

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ANNUAL SOCIETY MEETINGS

American Medical Association.....	1951
Oregon State Medical Society.....	1951
President, W. J. Weese	Secretary, R. F. Miller
Ontario	Portland
Washington State Medical Association.....	Seattle—Sept. 9-12, 1951
President, K. L. Partlow	Secretary, J. W. Haviland
Olympia	Seattle
Idaho State Medical Association.....	Sun Valley—June 17-20, 1951
President, R. T. Scott	Secretary, R. S. McKean
Lewiston	Boise
Alaska Territorial Medical Association.....	1951
President, A. J. Schaible	Secretary, W. P. Blanton
Fairbanks	Juneau

PERIODICAL SOCIETY MEETINGS

NORTHWEST

North Pacific Society of Neurology and Psychiatry,	April 20-21, 1951—Victoria, B. C.
President, C. P. Larson	Secretary, G. B. Haugen
Tacoma	Portland
North Pacific Orthopedic Society.....	Sun Valley—May, 1951
Secretary, J. K. Burton	President, W. H. Goering
Boise	Tacoma
North Pacific Surgical Assn...Vancouver, B. C., Nov. 16-17, 1951	
President, S. F. Herrmann	Secretary, J. A. Duncan
Tacoma	Seattle
Pacific Northwest Society of Pathologists	
.....April 6-7, Timberline Lodge, Mount Hood	
President, C. P. Larson	Secretary, G. A. C. Snyder
Tacoma	Portland

OREGON

Central Willamette Society.....	Second Thursday
President, W. W. Ball	Secretary, F. R. Asbury
Corvallis	Corvallis
Oregon Academy of Ophthalmology and Otolaryngology—Third	Tuesday, Old Heathman Hotel, Portland
President, Max Simons	Secretary, R. S. Fixott
Portland	Portland
Oregon Pathologists Association, Second Wednesday—Portland	
President, V. D. Sneedden	Secretary, J. E. Nohlgren
Portland	Portland
Portland Academy of Pediatrics.....	First Monday
President, S. G. Babson	Secretary, Edward Rector
Portland	Portland
Portland Surgical Society.....	Last Tuesday
President, J. M. Roberts	Secretary, J. W. Nadal
Portland	Portland
Southern Oregon Society.....	May, 1951—Klamath Falls
President, H. B. Currin	Secretary, F. C. Adams
Klamath Falls	Klamath Falls

WASHINGTON

Puget Sound Academy of Ophthalmology and Otolaryngology	Third Tuesday—Seattle or Tacoma
President, Frank Wanamaker	Secretary, Willard Goff
Seattle	Seattle
Seattle Academy of Internal Medicine—Quarterly, Third Monday	
President, Byron Francis	Secretary, K. B. Skubi
Seattle	Seattle
Seattle Academy of Surgery.....	Third Friday
President, J. C. Bennett	Secretary, D. A. Huckaby
Seattle	Seattle
Seattle Gynecological Society.....	Third Wednesday
President, C. D. Kimball	Secretary, Robert Plant
Seattle	Seattle
Seattle Neurological Society.....	Third Monday
President, W. F. Windle	Secretary, Frederick Becker
Seattle	Seattle
Seattle Pediatric Society.....	Fourth Friday
President, D. M. Harris	Secretary, W. A. Jaquette, Jr.
Seattle	Seattle
Seattle Surgical Society.....	Second Friday
President, B. P. Mullen	Secretary, R. B. Hearne
Seattle	Seattle
Spokane Surgical Society.....	Annual Meeting April 21, 1951
President, A. F. Cunningham	Secretary, F. L. Meeske
Spokane	Spokane
Washington State Obstetrical Society.....	Seattle—April, 1951
President, C. D. Kimball	Secretary, E. G. Layton
Seattle	Seattle
Washington State Society of Anesthesiologists.....	Fourth Friday
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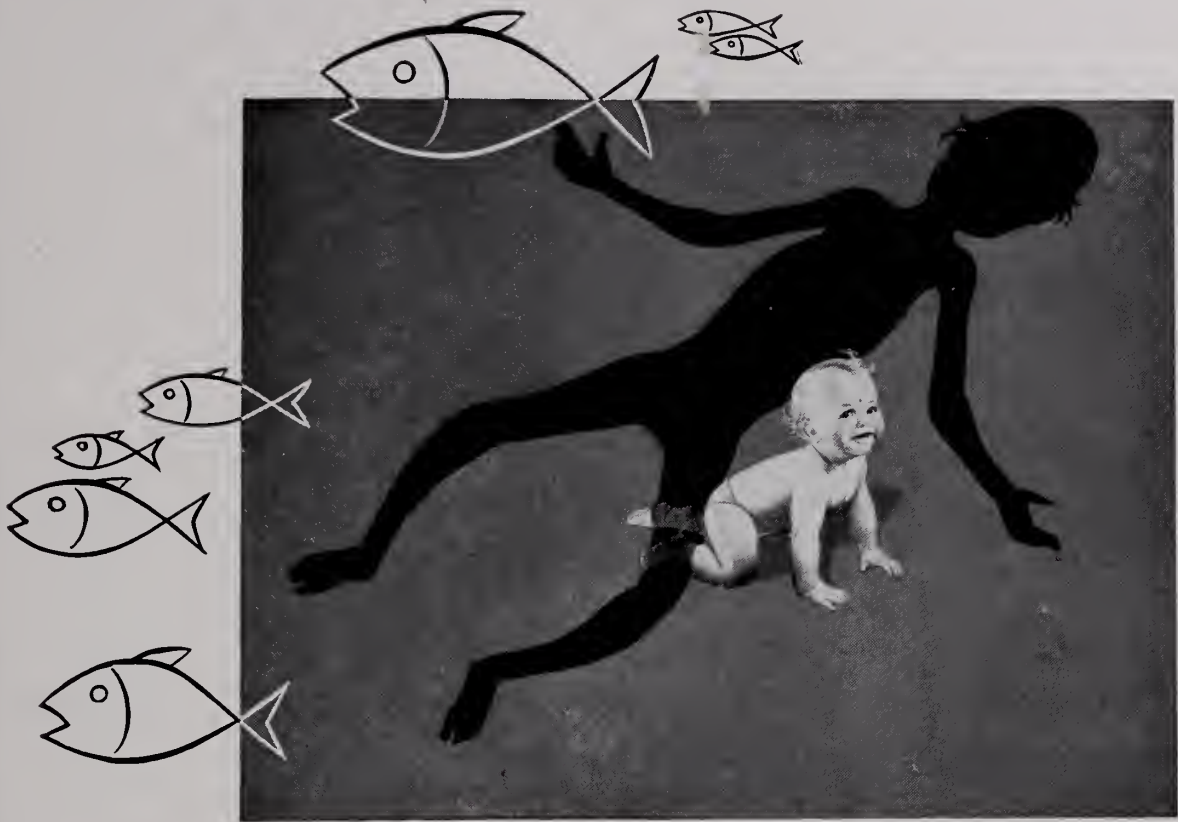
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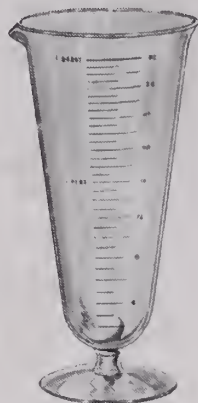
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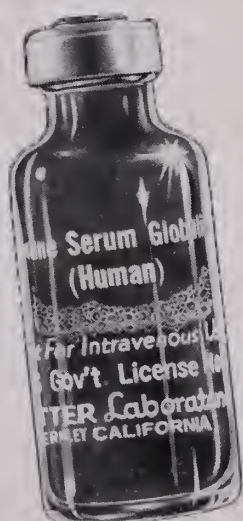
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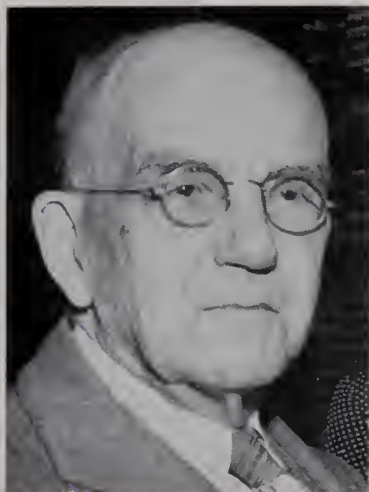
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Vol. 50

FEBRUARY, 1951

No. 2



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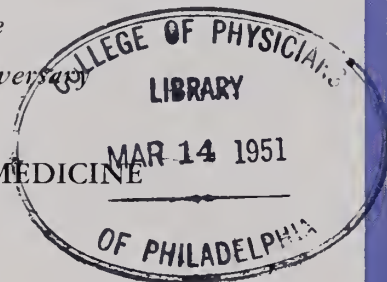
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Contents—See Page 6

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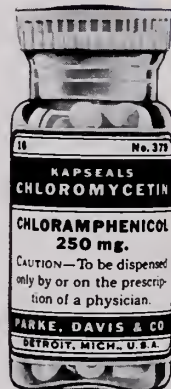
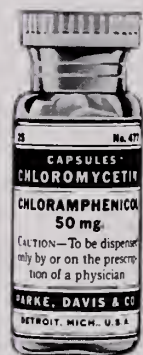


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Recinos, Jr., A.; Ross, S.; Olshaker, B., and Twible, E.: New England J. Med. 241:733, 1949.
Wood, E. J.: Lancet 2:55, 1949.

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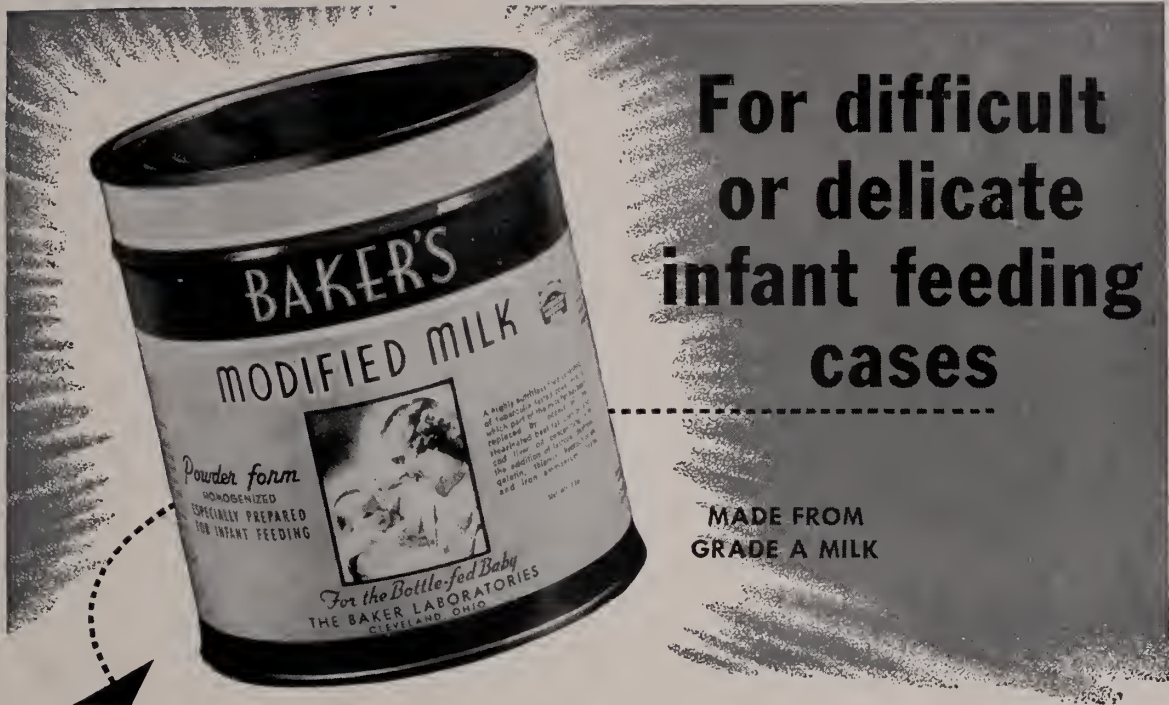
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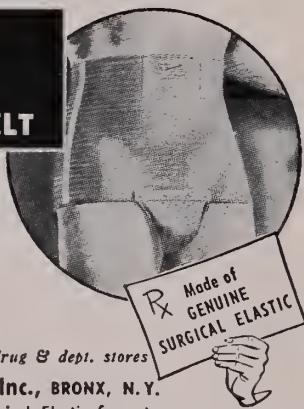
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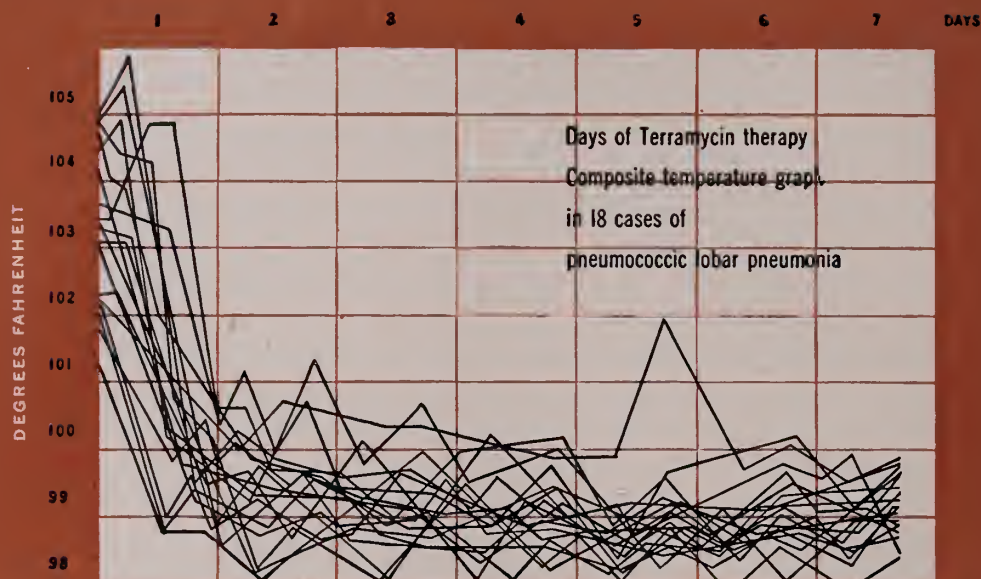
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7. People's League of Health: J. Lancet, 2:10, 1942.

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Yale J. Biol. and Med. 22:494 (July) 1950.

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*Fry, C. O.: J. Am. M. Women's A. 4:51 (Feb.) 1949

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(1) Mosenthal, H. O.: Management of Diabetes Mellitus: An Analysis of Present-Day Methods of Treatment, *Ann. Int. Med.*, 29:79 (July) 1948.

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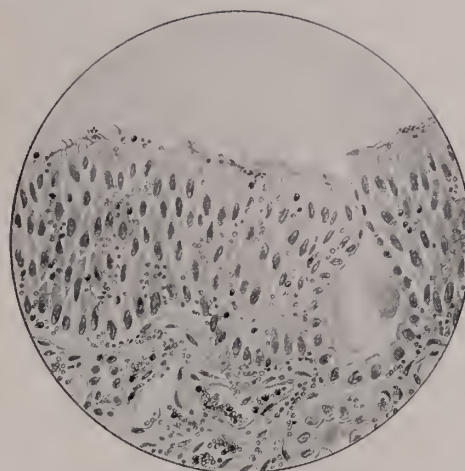
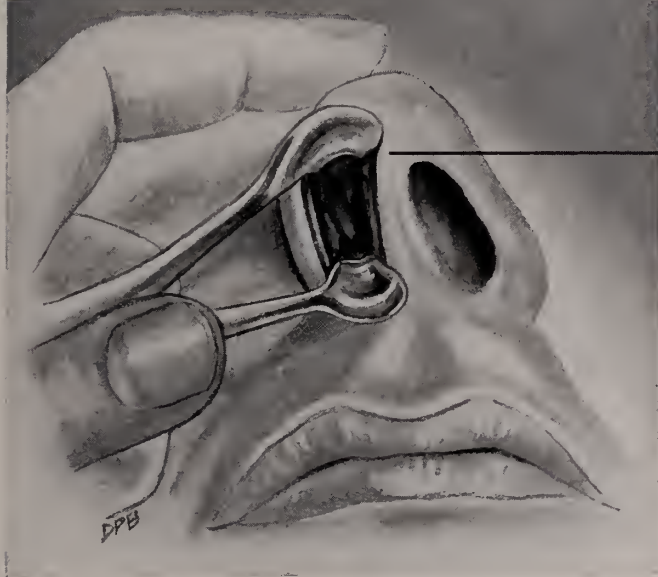
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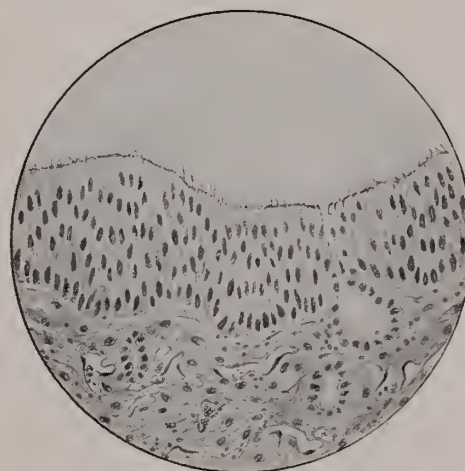
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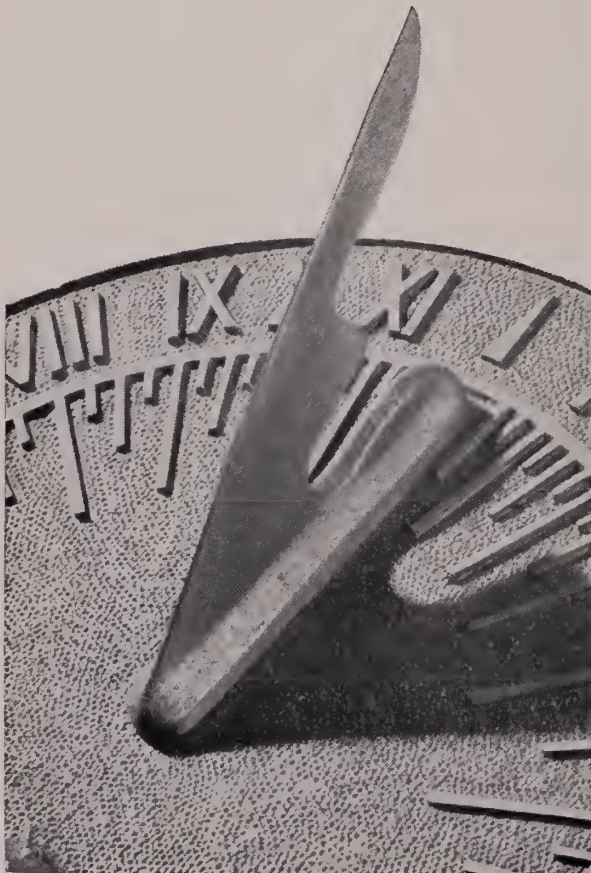
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NORTHWEST MEDICINE

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FEBRUARY, 1951

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EDITORIALS

1951 Objectives for Medicine

Clem Whitaker, director of the National Education campaign, summing up medicine's past accomplishments for doctors attending A. M. A.'s Cleveland session, warned them against complacency and then deftly outlined 1951 objectives on the "must list."

He said, "American medicine is in the strongest public position it ever has held because the people have been given the facts on this issue (socialized medicine) and have spoken out sharply against the abridgement of individual freedom in our country." There certainly is some element of truth in that statement and in the declaration that there still remain some "undone jobs and unsolved problems" for 1951.

Some of the bitterest attacks on medicine have been made by labor and Whitaker listed highest on next year's list for accomplishment the conversion to our way of thinking of as many of these groups as possible and the enlistment in our ranks of those labor groups who feel as we do. This is a job for every individual doctor and every medical society. Recent events indicate this is not as hopeless as it first appears. Unions are beginning to realize regimented labor would follow state medicine.

Also, Wage Earner Forum's recent survey showed 45.8 per cent of those contacted against compulsory health insurance, 26.9 per cent for it and 27.3 per cent "don't know enough about it" to make a choice. The latter group is a fertile field for both the government socializers and medicine. It's a question of who gets there first with the most convincing arguments.

Other groups with whom we have unfinished business, Whitaker said, "are P.-T. A., the League of Women Voters, the American Association of University Women and the Nurses Associations."

(Women's Auxiliary please take notice, that statement is a direct challenge to you. What are you going to do about it?)

Of equal interest to the physicians is that Britain is proceeding with the socialization of legal practice and rumors say the thought is spreading here. Whitaker summed up this situation with the statement: "Doctors should make it their business to enlist their lawyer friends in the work of acquainting the people with the threat of a regimented society which hangs over them." Farmers, too, should be educated to the fact that socialized farming is not good for the ranchers nor the consumers of their products.

Whitaker enumerated as new year objectives for the doctors, "better physician-patient relationship" with emphasis on "elimination of overcharges, office inefficiency and discourtesy." "And if you, the doctors, want to remain free * * * you must be alert, aggressive citizens, ready to defend what America has given us," he said.

Not only increased enrollment in voluntary medical and hospital plans must be accomplished, but "we need improved types of coverage * * * greater protection against prolonged catastrophic illnesses, more complete coverage of the regular costs of even ordinary illnesses," Whitaker continued. "It has long been apparent that plans which offer only group coverage will not satisfy public demand * * * that the growing demand for individual enrollment plans must be met."

Clem Whitaker isn't just an individual making noise in the darkness. His list of new year resolutions for the medical profession isn't just guess work or a long shot either. This "must program" is a result of long and anxious study of the problems that have vexed the medical profession for several years. These suggestions, if you please, have the full support of the highest leaders of organized medicine, or Whitaker wouldn't have dared make them publicly.

They, therefore, carry great weight and should be convincing to the rank and file of the medical profession.

ORIGINAL ARTICLES

Early Care of Traumatic Wounds of the Face*

CHARLES E. GURNEY, M.D. AND VERNER V. LINDGREN, M.D.
PORTLAND, ORE.

OUR complex and swift mode of living has brought to most practicing physicians frequent severe traumatic wounds of the face. Automobile accidents are by far the greatest cause of these injuries but industrial, home and hunting accidents account for many. A brief review of the related principles of plastic and reconstructive surgery should assist us in giving better treatment to these common and unfortunate injuries.

Injuries of the face vary in degree from a minor laceration of the skin to those mutilating catastrophes which involve all of the soft parts, plus their underlying cartilaginous and bony framework. The majority of the wounds are cared for by the family physician but the more severe injuries often require the collaboration of other specialists, including the anesthetist, neurosurgeon, dentist and plastic surgeon.

Injuries of the face differ from other injuries primarily in that their effects cannot be hidden. The fundamental principles of asepsis, hemostasis and gentle handling of tissues are as applicable to wounds of the face as they are to wounds elsewhere, even more so. Every effort should be made to reduce the resulting deformity and disfigurement to a minimum.

We have chosen to divide the treatment of wounds of the face into care of the patient as a whole and care of the wound itself.

The first consideration in the care of the patient is to stop any major bleeding. A generalized ooze is usually controlled by simple pressure over the bleeding area while bleeding from an open vessel will require a ligature.

One should strive to maintain an adequate blood pressure so as to prevent development of shock. While the scope of this paper does not permit a complete discussion of shock and its treatment, it should be noted that the level of arterial blood pressure is still the best index to the degree of shock. Although plasma is not considered a specific for traumatic or wound shock, it should be administered while whole blood is being typed and crossmatched. Relief of pain is equally important in the prevention of shock. Unnecessary moving of the patient should also be eliminated. Too often the patient is transferred from stretcher to cart and taken to hospital for roentgenograms not essential to emergency treat-

ment. This repeated movement jeopardizes the condition of the seriously injured patient and may produce more shock. It is best not to move the patient until he has been carefully examined and the physician is certain he is well stabilized.

As soon as the patient's condition permits, he should be transferred to surgery for definitive care of the wounds. It is advantageous to close all wounds within ten or twelve hours after an injury. Where this cannot be done, closure should be carried out as soon as possible. One can usually expect a good result when clean wounds are closed even after twelve hours with judicious use of chemotherapy.

Choice of the anesthetic agent is important. We prefer local anesthesia whenever possible, using 1 per cent procaine with three drops of adrenalin to the ounce. Local anesthesia is especially applicable when dealing with small wounds and a cooperative patient. With severe injuries or an uncooperative patient a general anesthetic is desirable and for this we prefer intratracheal anesthesia. This type of anesthesia is the safest of general anesthetics, when working on the face. It has the additional advantage of preventing aspiration of blood and fluids, since the lungs are protected by an inflated cuff around the anesthetic tube or the mouth is packed snugly with gauze. It assures the surgeon of a smoother anesthesia. Danger of vomiting is eliminated and the patient can be carried on lighter anesthesia. The tube can be inserted through the nose or mouth.

To prepare the field for surgery, the face is washed with soap and water. Ether is next used to remove the natural oils of the skin and other greases that might be present. The face is then washed with alcohol. The wound itself is cleaned only with hydrogen peroxide, followed by copious warm saline irrigation. Hydrogen peroxide is excellent for removing blood clots and loosening dirt. When using local anesthesia, one should prevent hydrogen peroxide from getting into the throat, for its expanding action with blood can obstruct the airway rather suddenly.

Alcoholic antiseptics should never be used directly in the wound as they are very irritating to the open tissues. It is sufficient to depend upon a gentle mechanical cleansing of the wound with peroxide and saline. We suggest never shaving the eyebrows, even though the laceration may extend through them. Several months are required before the hair in the brow grows out and, with proper preparation, the eyebrows are rarely the cause of infection.

One should search the wound carefully for for-

*Read before the Seventy-sixth Annual Meeting of Oregon State Medical Society, Gearhart, Oregon, September 27-30, 1950.

eign bodies. If road dirt is ground into the skin or wound, such as one sees in a brush bruise, this must be thoroughly removed at the time of the initial surgery. The pigment can usually be satisfactorily eliminated by scrubbing the area with a stiff hand brush. Since this procedure is quite painful, the patient preferably should be asleep. If the brush is unable to remove all the dirt, any residue can be removed by scraping with a curette or knife. The resulting skin abrasion should be covered with vaseline or borofax fine mesh gauze and a pressure type dressing applied. The final results of inadequate removal of these small pieces of road dirt in the skin is the objectional pigmented scar we occasionally see later.

Handle all tissue with extreme care and respect. Heavy clamps and forceps are passe. The skin should be manipulated as little as possible, using small skin hooks when available. Lacerations often cut the skin obliquely, leaving a thin feathery edge on one side. Since it is difficult to obtain a good closure with this type of laceration, we elect to cut each side of the wound with a sharp scalpel to give perpendicular edges.

There is no justification for radical removal of bruised tissue. The face has an excellent blood supply and tissue, that might not live elsewhere, usually survives on the face. Save every bit of tissue that can be salvaged. It might be needed later in further repair.

Closing the wound, if there is no loss of tissue, is not complicated or difficult. It is accomplished by accurate layer to layer closure, aided by first matching important landmarks as hair line, vermilion border or even facial wrinkles. If tissue loss is present, immediate repair is not the time for complicated plastic procedures. Extensive undermining should not be done to obtain closure. Tissue should never be pulled out of place simply for this purpose. Avoid all tension. It is much better to apply a split-thickness graft to the defect and prepare for definitive care later.

Fine suture material must be used throughout. Chromic 5-0 catgut sutures are used subcuticularly and 6-0 black silk for the skin. It is important to have the wound edges even or everted but never inverted. Where there is a tendency for edge inversion, mattress sutures will help correct this, otherwise, simple interrupted sutures are sufficient. Care should be taken to insert the sutures properly (figs. 1, 2, 3.)

Often fractures complicate the injury. When this occurs, the fracture must be reduced and immobilized. Fragments which are attached to tissue have a good chance of survival. One should remove only completely detached pieces of bone. Cartilage or bone should always be covered.

A proper dressing contributes immensely to the

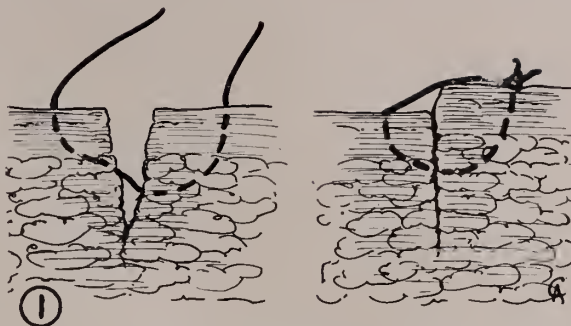


Fig. 1. INCORRECT METHOD.

The needle should leave and enter the raw edge of the wound at the same depth on each side. Otherwise one edge will heal at a higher level.

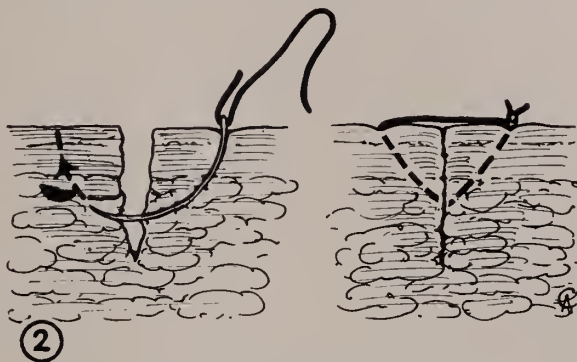


Fig. 2. INCORRECT METHOD.

Here the needle goes through both sides of the wound in one motion. In so doing, the direction of the needle is toward the edge of the wound. When this suture is tied, the point of greatest tension is on the surface of the skin and not in the corium beneath the surface.

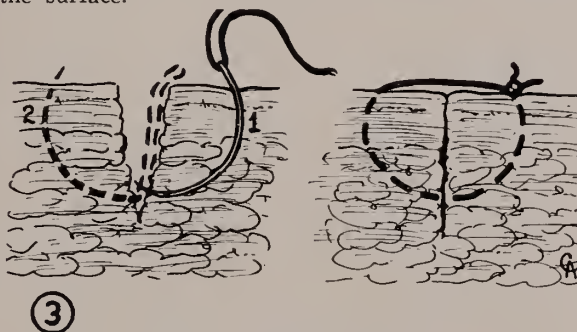


Fig. 3. CORRECT METHOD.

Two motions are required to insert the suture properly, as indicated in Nos. 1 and 2. The needle enters the surface of the skin in a direction away from the wound, so that, when the suture is tied, the point of greatest tension is in the corium beneath the skin surface.

comfort of the patient, as well as to a satisfactory cosmetic result. After the wound is properly sutured, vaseline or borofax is lightly applied along the suture line. Tension on the skin edges is prevented by the use of several one-half inch strips of elastoplast applied directly across the wound at right angle to the suture line. The tapes are stretched, when applied to the skin, so that as much tension is eliminated from the sutures as possible. Application of

mastisol to the adjacent skin will facilitate adhesion of the elastoplast strips (fig. 4).

Most facial sutures are removed, starting the third day, all being out by the fourth or fifth day. The elastoplast strips are replaced and worn until the tenth or twelfth day. Wide scars are sometimes due to motion in a newly formed scar, while it is still in the process of healing. This support of the newly sutured wound will help to make a narrower scar.

The majority of lacerations are benefited by a pressure dressing, consisting of sterile cotton held in place by a tensor or elastic ace bandage. If the pressure bandage should include the ears, they must be carefully padded with cotton to prevent a pressure sore over the ear cartilage. If the dressing is placed over an eye, we instill White's ophthalmic ointment and carefully adjust the pressure of the bandage to the comfort of the patient.

This type of uniform mechanical pressure dressing definitely influences wound healing by: Elimination of dead space, control of oozing of blood, limitation of venous and lymph stasis, immobilization of tissue, preventing contamination from without, preventing tissue swelling which in turn eliminates or at least decreases pain. The pressure dressing is left in place two to three days. Reapplication of this dressing is not essential after this period of time but the elastoplast tension strips on the skin should be retained.

Occasionally one sees "stitch marks" across a scar. When these are seen, it is reasonable to conclude that one or more of the following factors were present in the initial repair: There was too much tension on the suture; the suture material was too large; the sutures were left in for too long a period of time.

In early clean wounds chemotherapy may be eliminated. However, wounds contaminated with street dirt or other outdoor foreign material require special attention. Tetanus antitoxin or a booster toxoid injection should be given, depending upon previous immunization. For small wounds and no previous immunization, perhaps the usual 1500 units of tetanus antitoxin are adequate. In extensive contaminated wounds, puncture wounds or wounds that do not heal completely primarily, a total dose of 6,000-10,000 units is desirable, given in divided weekly doses of 3,000 units each.



Fig. 4. TENSION STRIPS

Strips of elastoplast tape (one-half inch) are stretched, then applied directly across the wound at right angle to the suture line.

SUMMARY

- A. Care of the patient as a whole:
 1. Stop all bleeding.
 2. Examine patient for other injuries.
 3. Prevent shock, if possible; treat shock, if already present.
 4. Avoid transfer of patient until his condition is well under control.
 5. Give tetanus antitoxin or toxoid in contaminated wounds, and penicillin.
- B. Care of the wound.
 1. Local anesthesia or intratracheal, if a general anesthesia is needed.
 2. Cleanse the wound gently with mild solutions. Hydrogen peroxide and saline are excellent. Never use strong alcoholic antiseptics directly in the wound.
 3. Be certain that all road dirt or pigment which might be ground into the skin is completely removed at the time of initial surgery.
 4. Exercise extreme care in removing so-called devitalized tissue.
 5. Initial care of the wound should *not* include complicated plastic procedures. The more simple the closure, the better.
 6. See that the wound is closed accurately in layers without tension.
 7. Apply a pressure dressing.
 8. Remove sutures early.



Perforated Peptic Ulcers*

WM. H. TOUSEY, M.D.

SPOKANE, WASH.

IT APPEARS to me that this might be an appropriate time again to review the subject of perforated peptic ulcers. In recent years, considerable controversy has arisen as to whether the problem should be treated in a radical or conservative manner. Historically, this condition was first recognized in 1679 by Boneti of Geneva, but in this country O'Hara was the first to describe such a perforation.

Mikulicz, in 1880, made the first surgical attempt to close such a perforation, which was unsuccessful. Yet, in the next 17 years he reported a series of 103 operations, the majority of which were successful. Since that time medical and surgical literature has contained many reports of this condition, reviewing mainly experience by individual surgical services in large institutions or by the entire surgical departments of those hospitals.

This series which I am presenting is from the surgical service of Dr. Valentine and myself at Sacred Heart Hospital, Spokane, Wash., during the past ten years and the statistics will therefore of necessity differ.

The anatomic and physiologic classification of perforated peptic ulcers has been differentiated by Monyihan into acute, subacute and chronic. Singer and Vaughn have added the term *formes frustes* to that group of perforations which becomes walled off or sealed within the first few hours after insult to the peritoneal cavity. Classically, the latter group presents the usual symptoms for only a brief period and frequently are unrecognized by the attending physician, who may attribute the acute short duration of symptoms to some other acute abdominal or cardiac condition.

The subject of chronic perforation need not receive too much consideration. Morton states that chronic perforation of the posterior wall of the duodenum is due to a slow penetrating process and usually involves the pancreas. It may present no unusual symptom and treatment is essentially that of uncomplicated duodenal ulcer. Finney and Hanrahan believe that treatment usually resolves into that of a perigastric abscess. Cutler, Zollinger and Bailey, in discussing gastric ulcer, state that chronic perforation usually occurs in the posterior wall. If there is protracted pain and failure to respond to medical treatment, subtotal gastric resection is indicated.

The acute perforation of peptic ulcer presents a well-known picture of intense agonizing upper abdominal pain, frequently in a patient without pre-

vious history of gastric distress or dyspepsia. It is this group of patients which offers the attending surgeon one of his few opportunities of rescuing that individual from generalized peritonitis and almost certain death.

In any discussion of perforated peptic ulcer, there are certain general considerations relative to this subject which should always receive the attending physician's most careful scrutiny.

1. *Time Interval.* It is universally agreed that the time interval between perforation and operation is of paramount importance in achieving a lowered mortality rate in this condition. Finney and Hanrahan state that not only is the life of the patient seriously jeopardized by the rapidly ensuing peritonitis but the frequently accompanying shock and agonizing pain demand the earliest possible relief. Quickness of action is the essence of good management in an emergency of this character and neither the physician nor surgeon can be held blameless who will allow a moment's unnecessary delay, even to make a positive diagnosis before opening the abdomen.

A number of observers have stated that the mortality in their series of cases for the second twelve-hour period following perforation is twice that of the first and after twenty-four hours the mortality rises to four times that of the first twelve hours. On the other hand, Olson and Norgore agree that early operation is important but the patient should have a reasonable chance of surviving the operation before surgery is instituted. If his condition is poor, the surgery should wait. They found that only 7.2 per cent of the patients actually showed shock but, if present, it is serious and should be treated before, during and after surgery.

They believe one should combat the peritoneal infection, if present, with chemotherapy. Since most of the peritonitis is chemical suction will prevent further spilling of the gastric contents. Their contention that early peritonitis is of a chemical and not a bacterial nature is supported by the fact that many workers have failed in their attempt to culture organisms from specimens taken from the peritoneal cavity in the first few hours after perforation.

2. *Electrolytic Fluid Balance.* When first seen, these patients simulate the picture of shock. Notwithstanding, Kelly states that the shock usually noted is not true shock as the pulse is usually below 100 and the blood pressure normal. Such routine laboratory studies as blood chlorides, carbon dioxide combining power, complete blood studies are advis-

*Read at Twelfth Annual Meeting, Spokane Surgical Society, Spokane, Wash., April 8, 1950.

able, since an occasional perforation may have been preceded or accompanied by a massive gastrointestinal hemorrhage or nutritional hypoprotein anemia. Any abnormal findings here can be rapidly corrected prior or during surgery by immediate parenteral administration of required electrolytes, blood, blood plasma or seroalbumin. However, if too much time is required to obtain this information, the surgeon should feel justified in proceeding with the indicated surgery.

3. *The Choice of Anesthetic.* This must depend on the availability of competent administration and the personal preference of the operating surgeon. Many men prefer spinal, although I have always used some type of general anesthetic, usually sodium pentothal supplemented by oxygen, nitrous oxide, ether and curare when indicated.

4. *The Question of Incision.* This must be determined by the judgment and experience of the operator. At the present, perhaps an equal number of operative procedures are done through a transverse or upper right longitudinal incision. Initially, these incisions should be small to enable exploration only and, if necessary, they may be enlarged to permit more extensive operative procedures. I have come to this conclusion since a considerable number of these wounds become secondarily infected and are prone to disrupt. If the causative pathology is found through a small incision and corrected, the morbidity and hospital stay of the patient may be appreciably reduced.

5. *Choice of Operative Procedure.* There remains a considerable variance of opinion as to whether the condition is best treated by conservative or radical surgery. In addition to the more popular procedures of simple closure and subtotal gastric resection for acute perforated peptic ulcers, some workers have advocated such procedures as gastroenterostomy, gastrostomy, pyloroplasty, simple excision and primary closure of the ulcer area.

The great majority of present-day surgeons, however, prefer to consider of primary importance the saving of the patient's life by the simple closure of the perforation and reserve a more formidable radical treatment for those patients in whom the following conditions are encountered: Perforated carcinoma of the stomach with a resectable lesion, perforated ulcer with simultaneous or recent gross hemorrhage, perforated ulcer with pyloric obstruction, recent perforation in a young individual with a long history of peptic ulcer with poor cooperation but in good surgical condition.

It should be emphasized that in any study of statistics, in which mortality comparisons are made between advocates of radical versus conservative surgical treatment, due consideration should be given to the fact that in most instances radical procedures have been attempted on only the compara-

tively good surgical risks, whereas many of the near moribund patients have been subjected to a simple ulcer closure.

It is my opinion, and the policy we have employed, that the exact type of surgery must await exploration of the abdomen. In the series being reported, the vast majority were treated by simple closure.

SURGICAL PROCEDURE

Many authors have established definite routine methods for closure of the perforation. Purse strings or repeated layers of closure are unnecessary as they tend to obstruct the lumen of the bowel.

Graham places three interrupted catgut sutures parallel to the long axis of the duodenum or stomach, one above, one below and one through the perforation; then places a piece of omentum, either attached or detached over the opening and ties it in place with the sutures. Baritell simply tacks a tag of living omental fat over the opening with a few interrupted cotton sutures.

Personally, I believe that no routine method of repair is applicable in all cases, and it seems to me the best method is that which requires less trauma and less time, whether it is a suture through the bowel, a plug of omentum or a combination of both. The degree of edema, induration or necrosis present must be considered in selecting the method of closure.

All free fluid in the peritoneal cavity, which is accessible without undue trauma, should be removed by suction. Most surgeons are of the opinion that no drains should be placed in the peritoneal cavity. Again, I think that this is equivocal and should or should not be done, based on the operator's own experience. Most of our cases have been drained. The peritoneum will absorb rapidly and I suppose recovery of our patients was not changed one way or another by drainage. The abdominal wall is closed by layers in the usual manner, with interrupted steel wire sutures reinforcing the fascia. Sulfonamides are not placed in the peritoneal cavity because I believe there is primarily a chemical and not a bacterial peritonitis.

Postoperatively, a nasal gastric tube is placed in the stomach with constant suction. After approximately forty-eight hours, sips of water are permitted and on the following day, if peristalsis is normal and there is no distention, the tube is removed. Liquids are gradually increased until the patient is on a medical ulcer management. The fluid balance is maintained by intravenous fluids, depending on individual requirements. The antibiotics are used when indicated for any complications, as are aminoacids and vitamin preparations.

CASE REPORTS

The present series of cases being reported consisted of twenty-five, ranging in age from 19 to 67

years. Of this group, there was one female and twenty-four males. Of the total number, fifteen gave histories suggestive of peptic ulcer, nine of these fifteen having had previous diagnostic roentgen films prior to their episodes of perforation. Of particular interest is the fact that three of the fifteen were hospitalized and on strict medical management for their ulcers at the time of perforation, one of whom had been hospitalized three years previously because of massive gastrointestinal hemorrhage. The time interval between onset of symptoms and surgery in this group varied from two to thirty-six hours. Of the twenty-five cases reported, twenty-one were subjected to roentgen films of the abdomen for free air prior to surgery and all were reported by the roentgenologist as having detectable free air in the peritoneal cavity. In each of these cases there was clinical evidence of obliteration of the normal liver dullness on physical examination. The average hospital stay for this group of patients was seventeen days.

Postoperative complications. There was one evisceration, occurring on the tenth postoperative day in a sixty-four-year-old male who developed delirium tremens on the second day postoperatively and required constant physical restraints. Following repair of the wound disruption, he made a gradual progressive recovery.

Repeated postoperative gastric hemorrhage was observed in only one case, a fifty-nine-year-old white male who had severe bleeding two months following his surgery. He refused further surgery and eleven months later again had profuse gastrointestinal bleeding. The third episode of hemorrhage recurred one month later, at which time he submitted to gastric resection. Pathologic examination of the stomach showed no evidence of malignancy and he has remained in good health to date, some five years later. This individual had a gastroenterostomy performed some twenty-five years prior to his perforation.

One patient developed a bilateral epididymitis on the second postoperative day which materially delayed his recovery.

Of particular interest was a case of a twenty-nine-year-old white male who was admitted to the hospital after twelve hours of severe abdominal pain and vomiting. He was observed in the hospital for another twenty-four hours and then transferred to us for surgery. There was a large perforation one inch proximal to the pylorus on the anterior surface of the stomach. There was no attempt at walling off the perforation and fluid was seen flowing from the stomach. The peritoneal cavity contained a great amount of free fluid, beer and food particles. A simple closure was done and one cigarette drain was placed in the right gutter. His postoperative course was rather stormy with temperature up to

103.5, pulse 126, resp. 30. He developed pneumonia and a severe wound infection but eventually recovered and was discharged some three weeks after operation.

Of our group of twenty-five cases, only one failed to recover, making a 4 per cent mortality in this series. This individual was a 67-year-old male who made an uneventful recovery until the tenth postoperative day, when up and about he developed a cardiac arrhythmia which persisted intermittently until the sixteenth day, when he suddenly expired. Autopsy was not performed and, though this appeared to be a cardiac death, we are including it in our series as operative mortality.

SUMMARY

I have found that we are in almost complete agreement with DeBakey, who sums up the case for simple ulcer closure as follows:

1. Perforation is a surgical emergency and the procedure of choice is the one which effects adequate repair in the quickest and simplest manner.

2. The morbidity and operative mortality are decreased.

3. Prompt healing occurs and in the majority of cases is permanent.

4. Danger of subsequent constriction and obstruction is infrequent and, even if it occurs, subsequent operation may be performed under more ideal conditions.

5. Performance of an additional procedure is not only usually unnecessary and subjects the patient to an unjustifiable risk but also frequently does not prevent the development of complications such as recurrence, perforation, hemorrhage or new ulcer formation.

I wish to point out that the old theory, "perforation cures the ulcer," is ridiculous as the future of these patients depends largely on themselves. If, since the original onset of ulcer symptoms, these people had remained on a reasonable ulcer diet and had refrained from smoking, they would probably have not perforated and if, after operation, they continue in their same usual haphazard way of life, they will eventually have recurrence of symptoms. If, on the other hand, they restrict themselves to a good medical routine, they will have no more trouble than the average ulcer patient. There should be a good follow-up in all cases and if, in spite of good medical management, stenosis or hemorrhage occurs, then additional surgery is indicated.

The surgeon should always remember that peptic ulcer has always and will always remain primarily a problem of medical management and the family physician or internist shall be the one who shall effect a cure in this all-too-common condition much more frequently than those who deal only with the complications.

The Physiologic Position for Delivery*

FORREST H. HOWARD, M.D.
POCATELLO, IDA.

IN THE past few decades the physiologic approach to medical problems has dominated medical thought. Nose and throat surgeons rarely remove turbinates but rather remove excess tissue from the nasal septums. Medical management of peptic ulcers is employed along with psychotherapy to greater advantage than the multitude of operations employed twenty years ago for the unfortunate dyspeptic. This communication is to develop this thought process as pertains to the position of the parturient woman during her delivery.

The conventional positions now generally in use in obstetrics are the modified lithotomy position, with the patient on her back, and to a lesser extent the Sims position, wherein the patient reclines on her side, the upper knee being drawn up on the abdomen. Most lecturers in obstetrics pass lightly over the so-called physiologic position, which is the squatting position. Williams' textbook,¹ describing the second stage of labor, says "the primipara . . . if left to herself, will usually assume the crouching or squatting posture." Buxbaum,² discussing delivery in ancient times, describes "the squatting position, the perineum being protected by a mound of sand." Pearl Buck, in her novel, the "Good Earth," has her heroine squat in a corner of her Chinese hovel to deliver her first born. And lastly, obstetrical chairs seemed most natural to the accoucheurs of the middle ages.

One method of determining what is the physiologic position is to compare the position of the act in nature. The most nearly akin to delivery is the daily bowel movement, humorous considerations notwithstanding. Most quadrupeds perform this function in the horizontal and they deliver their young similarly. Bipedes, including man, usually perform the bowel function in the squatting position. Williams' statement, previously quoted, suggests that the inexperienced primipara will wish to assume the squat, while the wise and civilized multipara will lie on her back to perform expulsion of the foetus.

If one grants that the physiologic position for delivery is the squat or crouch, there must be other considerations that make this position desirable. The first consideration is the law of gravity; it is simpler to overcome friction falling than sliding. The second consideration is the effect that gravity

has on the contents of the presenting part, when the presenting part is the head. The logic of this last statement will be developed.

Most of us know that water is a liquid which is compressed with difficulty. Therefore, if you float a match stick in a tightly corked, well-filled bottle, and then compress the bottle, the match will submerge, for the wood compresses more easily and becomes relatively more dense than the water. Considering the cerebrospinal fluid as water, which it is in the main, we can assume that compressed brain tissue becomes relatively heavier toward cerebrospinal fluid, thereby tending to seek the most dependant position in the cranium.

In the most common position, left occiput anterior, moulding of the head causes the suboccipital and frontal margins of the falx to approach, narrowing this diameter. This, in turn, is compensated for by lengthening the parietooccipital to basalar diameter, putting this diameter on a stretch. Thus, in an anterior occiput, the nose and frontal area of the fetus is the most dependent, in the lithotomy position of the mother. The weight of the brain substance, therefore, sinks toward the frontal area and on extension of the head, shifts towards the floor of the cranium. Thus, the weight of the brain substance is centered farthest from the point of maximum stress on the falx. This abnormal stowage of cargo could, in a borderline case, be the cause of a tentorial tear. (See Illustration)

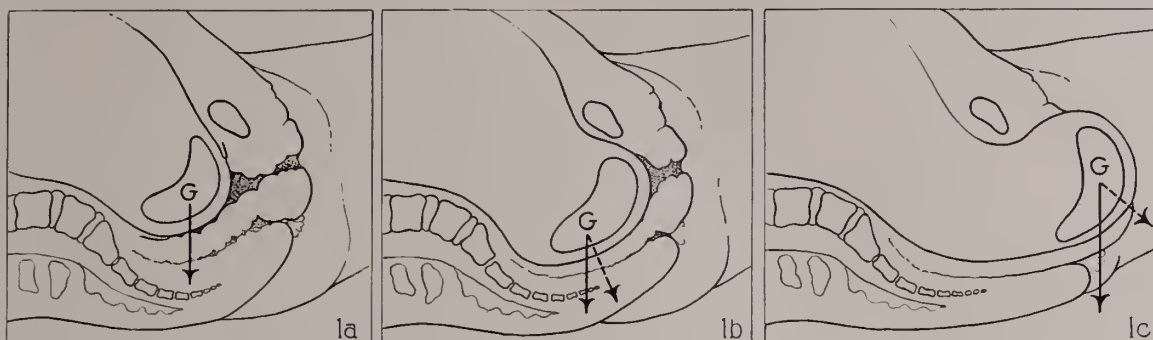
However, were the physiologic position used, the most dependent portion of the cranium would be the region of the occipital fontanel. The mass of weight would be on either side of the region of the most stress on the falx, thus tending to cushion the stress. Upon extension of the head, the center of weight will shift in a small arc to the frontal region. In occiput positions, posterior, the weight would shift toward the occiput on extension of the head.

With the increase in popularity, during and since World War II, of caudal and saddle block anaesthesia, it is logical to discuss the physiologic position for delivery as pertains to these anesthetics. I submitted the essence of this paper to my service medical journal during World War II. It was accepted for publication in August, 1943, but never published. In discussing the physiologic position with several commanding officers and heads of dependent care departments, the essence was summed up, "have you ever delivered a woman in this position?" The answer being in the negative, the advice

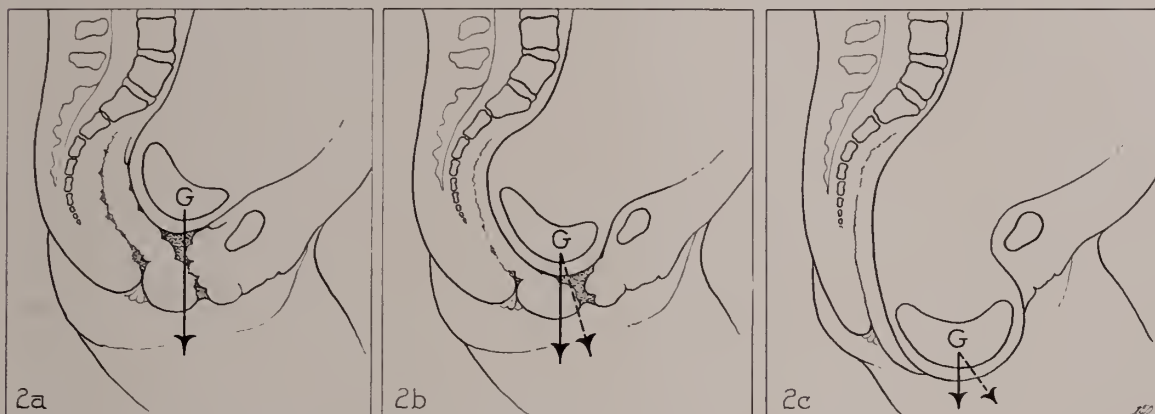
*Read at University of Rochester Medical School Alumni Meeting, New York, Oct. 12, 1950.

1. Stander, H. J.: Williams' Obstetrics, Ed. 10, pp. 313-314. N. Y., D. Appleton & Company, 1950.

2. Buxbaum, H.: History of Obstetrics, Illinois M. J., 61:118-125, Feb., 1932.



SHIFT IN THE POSITION OF GRAVITY IN THE HORIZONTAL POSITION



SHIFT OF GRAVITY IN THE ERECT SQUAT

- 1a. The force of gravity with the head below the spines, the mother in the horizontal.
 1b. The head crowing.
 1c. Extension of the head.
 2a, 2b, 2c, are merely 1a, 1b, 1c, rotated to the erect

from the horizontal. The main weight of the mass of the cranial contents remains in the region of the occiput in the erect position, whereas the mass shifts from the occiput to the frontal area in the horizontal.

—Illustration by Mrs. Kathryn Bittick, Portland, Ore.

then given was to "go back to Idaho and put your idea into use." This I did in a roundabout manner, first by acquiring a practice and acquainting myself with saddle block anaesthesia, then building a table which would adapt itself to the physiologic position for delivery.

Those who are using block anaesthesia are familiar with the fact that the mother has lost the expulsive urge, midforceps are not unusual and outlet forceps are almost routine with a block. This is outweighed by the safety to the mother with block anaesthesia and the babe is safest with the block or caudal over all other methods of anesthetization to the mother.

The method of anesthetizing the mother is as follows: When the pains are every five minutes and quite strong or the cervix is five cm. dilated along with regular and strong pains, the mother is given a block anaesthesia of 1 cc. of 1:200 nupercaine, 1 cc. of 10 per cent dextrose with .05 cc. of 1:1000 adrenalin. This is introduced intrathecally in the third or fourth lumbar interspace. The mother is given $\frac{1}{4}$ cc. of neosynephrine intramuscularly immediately and the blood pressure taken. Care is taken that the anesthesia does not go above the

lower costal borders but remains between the umbilicus and costal borders. This is accomplished by putting the mother's head on a folded pillow.

The blood pressure is followed every five minutes for two or three recordings and, when it is stabilized, the mother is again examined to determine the stage. Quite frequently the amount of dilation, since the examination just before the block was given, will amaze the examiner. When the cervix is fully dilated, the mother is placed on the table and station determined. If the head is at or above the spines, elevating the backrest to 60° with the horizontal and allowing the patient to remain in the position for 15 minutes to one-half hour will allow the head to come down to the perineum and be delivered. Delivery, when the head is on the perineum, is easier accomplished. Elevating the patient from 30 to 45 degrees and applying slight pressure to the abdomen will accomplish the delivery of the head very easily. It is remarkable how easily the head delivers in these circumstances without the aid of forceps.

Some caution should be observed. The blood pressure of the mother should be carefully watched. If it falls below 100 systolic, $\frac{1}{4}$ cc. of neosyne-

phrine solution should be given. It has been shown that the critical blood pressure, below which insufficient oxygen and nourishment is given to the fetus, is about 90 systolic. The anesthetic should be given long enough before the expected arrival so that its proper "setting" can take place. If the blood pressure of the mother falls to 100 and cannot be elevated with vasopressor drugs, the elevation of the table should not be continued. So far I have delivered approximately twenty-five mothers without complication.

The table which I have designed and used has a conventional backrest and sliding footrest. The departures from the usual are that the backrest can be elevated to 90 degrees, the knee crutches are secured to this back piece and are supported by L-shaped square steel rods $1\frac{1}{2}$ inches thick. One bar of the L holds the crutch and the other is held in a lock device which controls the width that the knees are held apart. A device which is best described as the posterior part of a bucket seat is adjusted to the table in a manner that it lightly supports the buttocks. A sliding foot piece insures that the babe, once delivered, will not

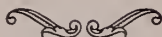
fall to the floor in case the accoucheur should be otherwise occupied. Crazy wheels with one set of wheel locks provide locomotion.

After the babe is delivered, the mother is given the usual oxytocic, lowered to a horizontal, the placenta delivered and any necessary perineal repairs made. The fact that this table has the so-called crazy legs makes but one transfer of the patient necessary from the table to her own bed. She is perfectly comfortable laboring on the table. This is much appreciated by the nursing staff.

Patent rights have been applied for on this table. When granted, they will be assigned to a nonprofit corporation. A similar table can be acquired by communication with the author.

CONCLUSIONS

1. The physiologic position for delivery is the sitting or crouching position.
2. A mechanism whereby tentorial tears are caused in the lithotomy position described and it is shown that the physiologic position minimizes this danger.
3. An obstetric chair-table is described.
4. This is a preliminary report.



STATE SECTIONS

**OREGON STATE
MEDICAL SOCIETY**



**ANNUAL MEETING
1951**

President, W. J. Weese, M.D., Ontario Secretary, R. F. Miller, M.D., Portland Executive Secretary, Mr. C. C. Faley, Portland

Opinions, Views or Comments presented in articles appearing in this section are those of the individual authors and are not necessarily those of Oregon State Medical Society.

Medical Notes

Hospitals and Picket Lines

Doctors have believed for many years that hospitals, by reason of being an important factor in enabling the medical profession to discharge its responsibility for a community's good health, are immune to mass labor disturbances including strikes. This belief was based on the reasonable assumption that the public interest is paramount, transcending that of either hospitals or labor unions.

This assumption has recently been subjected to a couple of rude jolts in Multnomah County, where at this writing picket lines are walking in the rain outside two Portland hospitals. Emanuel Hospital, which had no contract with a union, has been picketed for "organizational" purposes for several months. Good Samaritan hospital, which has had a contract with a union for several years, enjoys a picket line resulting from the walkout of several union employees in a definite strike. In Emanuel the employees, whether union members or not, did not leave their jobs; in Good Samaritan most union member employees did walk out. Picketing in both instances has been of the peaceful or non-mass type to date, with a sprinkling of attempts at coercion through verbal "promises" to "get" nonconforming individuals and the use of much jotting in notebooks to impress the timid.

Cleared of all propaganda, the labor disturbances seem pretty well to boil down to the question of union "security" which, in union terminology, means the little matter of employers requiring employees to join the union thirty days after onset of employment, with the employer collecting union dues through payroll deductions. This the hospitals have declined to do, while expressing understanding of the union's position and offering no objections to any voluntary arrangements made between hospital employees and the union.

Portland doctors are continuing to minister to their patients, union and nonunion alike, in both institutions, on the ground the welfare of the patient is paramount. Most doctors have considerable understanding of some union problems and practices and feel it is most deplorable the current troubles were precipitated as they were without full regard to the public interest.

There are a number of informed individuals who question the legitimacy of the picketing of these hospitals. Section 152 of the Labor Relations Act was specifically amended in 1947 to state definition of the term employer "shall not include . . . a corporation or association engaged in the operation of a hospital . . ." where the proceeds were not paid to individual stockholders. Both Emanuel and Good Samaritan Hospitals are church owned and operated institutions, without private stockholders.

That the precedence of the public interest surmounting all other issues is understood by the public generally is made clear by both Portland daily newspapers, themselves considerably "organized" both mechanically and editorially.

The *Journal* stated: "The union shop seems to be the main issue in this dispute. While the union shop may have its place in industrial disputes, it seems incongruous in the operation of a hospital, where the main issue is whether a patient lives or dies."

The *Oregonian* quoted the words which made Calvin Coolidge President of the United States: "There is no right to strike against the public safety by anybody, anywhere, any time." It concluded the strike "offends public opinion, and weakens respect for organized labor."

Settlement of the two Portland hospital labor disputes may prove more difficult than might be expected. It has been said the strike actions in Portland were but the beginning of a move designed to unionize all nonprofessional employees of hospitals throughout the state, with inclusion of professional employees to follow later. If this is correct it must not be assumed the union will abandon its objectives lightly. On the other hand, from the practical standpoint of preventing operation of the two hospitals, both union actions have been expensive failures. Unfortunately this involves union prestige, and possibly that of some union leaders who, following unwise counsels, now find themselves in a position from which retreat is difficult. Yet a satisfactory termination in the public interest should be found.

O. M. W.

Pete the Pest Says

How to Get Steak: Ruckus at Sun Valley at time of annual meeting of Idaho State Medical Society, resulting in critical comment in N. W. MEDICINE, had happy aftermath for two Idaho medical society officials. Blew thick, juicy filets mignons right into their laps! For free!

Idaho executive secretary, with delegate to A. M. A. journeying to Cleveland for recent A. M. A. aboard U. P. "City of Portland," found themselves dinner guests of the railroad on instructions from higher up. Dining car steward spotted them on entrance, escorted them to favorite table, and plied them with special goodies set aside just for the purpose of making amends for any difficulties at Sun Valley. Commented delegate from another state seated nearby: "Too bad for us there's no Sun Valley in our state."

Duly Qualified: Portland medico, recently completing second term as society treasurer, amused some fellow docs by performance at annual feast. Sauntered cautiously into the hall being prepared for the festivities, casually strolled among tables set for guests, wandered to liquid refreshments department, obtained necessary ingredients in glass, and leisurely absorbed contents of same while edging way toward entrance doorway. Apparently satisfied with quality of goods and arrangements then went outside and purchased banquet ticket. Sez one observer: "Instinct of a born treasurer in action."

Odd Quirk: Portland's Good Samaritan Hospital staff docs, who anticipated the worst when labor fracas struck their workshop, received pleasant surprise. Service in certain portions of the institution, instead of suffering curtailments and increased time-lags, actually improved! Made it seem like those who stayed on job were ones interested in turning out good job, and when others walked out their efforts were either increased to fill gap, or released from previous restraints. Sez one staff oldtimer, "If a strike was all we needed, we should have had one sooner."

On the March

In business and headed your way is a new force in the prepayment medical care field, the Blue Cross Health Service, Inc. A New York insurance company, wholly Blue Cross, the concern is the outgrowth of the efforts at Los Angeles and French Lick to form a "joint" insurance company with Blue Shield plans to meet the alleged needs of so-called "national" accounts. When the proposals for a joint venture were not approved by the Blue Shield plans on schedule, the Blue Cross plans indicated they were going ahead with their insurance company proposals regardless

and did so. As a result Health Service Incorporated has come into being and is now in business.

Feature of the venture which should have the greatest significance for all doctors in view of the facts that Blue Cross plans are hospital plans and that official medical circles are viewing with considerable apprehension the matter of hospitals indulging in the practice of medicine, is that Health Service Inc. is empowered to underwrite both hospital and medical risks.

Among the first accounts written on the uniform benefits at uniform rates basis, according to a recent Blue Cross news release, is the United Press group of 800 members and their dependents.

Antitrust Suit Appealed

On the last day on which an appeal could be taken from the decision of Judge Claude McCulloch dismissing the government's antitrust suit against the Oregon State Medical Society et al, the department of justice filed notice of appeal. This action carries the matter directly to the U. S. Supreme Court.

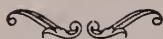
If usual procedure is followed, briefs will be filed by the respective sides and arguments before the supreme court will be made by opposing attorneys. The court will then render a decision which will be final. It is anticipated this may take several months, so that a decision before autumn is not anticipated by Oregon lawyers familiar with such matters.

Obituary

DR. T. HOMER COFFEN, 74, prominent Portland internist, died on January 3, 1951, after a lengthy illness.

Dr. Coffen was born in 1877 in Minneapolis, Minnesota, where his early schooling was obtained. He attended Penn College and took his medical degree at Johns Hopkins in 1906. For the next seven years he engaged in postgraduate studies at Cornell Medical School and other eastern centers, and in 1913 came to Portland to establish his practice and accepted the post of professor of clinical medicine at the University of Oregon Medical School.

In addition to his interest in clinical medicine, Dr. Coffen found time to engage in a number of duties associated with his profession. He was a former president of the Multnomah County Medical Society, secretary of the Oregon State Medical Society and a former member of the board of governors of the American College of Physicians. He was a member of the American Medical Association and a number of other associations connected with his specialty. He retained an interest in the University of Oregon Medical School throughout his life, being emeritus professor of medicine at the time of his death.



SEATTLE TIMES JAN. 24, 1951

Dean of U. S. Medical Editors Observes 90th Anniversary

Messages of congratulations poured in today on Dr. Clarence A. Smith, dean of American medical-journal editors, who is observing his 90th birthday anniversary.

Dr. Smith helped to start Northwest Medicine in 1903 and has been editor of it continuously.

The 50th anniversary of the medical journal will be observed next month—a little ahead of time.

"There was a slip-up in 1909," Dr. Smith explained, with a twinkle in his eye. "I was practicing physician editing the journal as a sideline, and I was ignorant about the publishing business. When we changed the size of the journal in 1909 to make it larger, we put a new volume number on it. So in that year we had two volume numbers.

"That's why the journal carries Volume 50 this year, although we really are beginning our 49th year."

Dr. Smith said he supposed there would be another fitting observance of the real half-century mark for the widely respected journal next year.

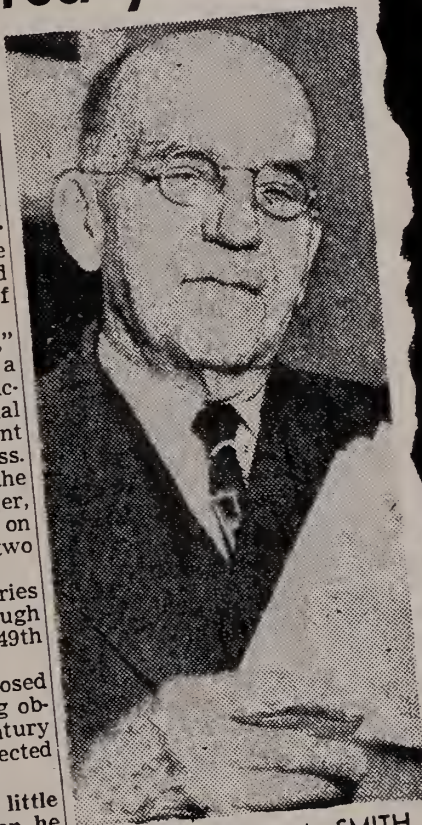
Dr. Smith said he was a little embarrassed by the attention he was receiving on his birthday. He planned to mark the day quietly by having a few friends drop in at 1305 E. Mercer St., where he and Mrs. Smith have lived for 48 years.

Dr. Smith retired from active medical practice in 1937.

"I figured 50 years was long enough," the genial physician said.

Because of his keen interest in medicine, Dr. Smith has continued to edit Northwest Medicine, which is the official publication of the medical associations of Washington, Oregon, Idaho and Alaska.

Dr. Smith graduated from Yale



DR. CLARENCE A. SMITH

He's a little embarrassed

University in 1882 and received his medical degree from Columbia University in 1887. Two years later he came to Seattle, a few weeks before the big fire. His brother, the late Superior Judge Everett Smith, "sold" him on Seattle.

In 1909, Dr. Smith was president of the Washington State Medical Association.

"I'm the last of all the doctors who were practicing in Seattle when I arrived in 1889," Dr. Smith said.

Oregon State Medical Society
MEDICAL-DENTAL BUILDING
PORTLAND 5, OREGON
January 23, 1951

Dr. Clarence A. Smith, Editor
Northwest Medicine
309 Douglas Building
Seattle 1, Washington

Dear Dr. Smith:

The Oregon State Medical Society extends to you its heartiest congratulations and most cordial good wishes on the occasion of your ninetieth birthday and the beginning of your forty-ninth year as Editor of "Northwest Medicine."

As one of the leaders in the establishment of our regional journal and as Editor since its inception in 1903, you have played a notable role in the advance of medicine in the Pacific Northwest. Your faithful reporting of medical events and your stimulating editorials on the problems that have confronted the medical profession of the North Pacific area during half a century have placed us deeply in your debt.

Your fine editorial judgment and the resulting high quality of the scientific section have long made "Northwest Medicine" one of the most quoted of all state journals and led it to a superior position among medical periodicals.

We salute you for your distinguished service to medical journalism and to two generations of Pacific Northwest physicians.

Fraternally yours,

William J. Meese, M.D.
William J. Meese, M.D.
President

Washington State Medical Association
338 White-Henry-Shurt Building
Seattle 1, Washington

January 20, 1951

General Officers

President—Kenneth L. Partlow, M.D., Olympia
President Elect—Richard A. Benson, M.D., Bismarck
Vice Pres.—Arthur E. Lion, M.D., Spokane
Secy.—Trent—W. Hasland, M.D., Seattle
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Public Committee—Che—Donald C. Corbett, M.D., Spokane
Legal Defense—Che—James H. Brier, M.D., Seattle
Leg. Committee—Che—V. W. Spickard, M.D., Seattle
Vice Secretary—Ralph W. Neel
Treas.—Edward L. Rosing

C. A. Smith, M.D.
Northwest Medicine
Seattle, Washington

Dear Doctor Smith:

Last Sunday the Board of Trustees met in Seattle and we were reminded that in February of 1951 you will have completed fifty years as Editor-in-Chief of Northwest Medicine Magazine.

By unanimous action of the Board I was directed to express to you the congratulations and appreciation of the doctors of this state for the many years of service which you have devoted to the profession.

It is a real pleasure for me to convey to you not only my personal sentiments but also the feeling of respect which we as doctors of this state feel for you. It must be a source of great satisfaction to you to compare the early issues of Northwest Medicine with the present publication and to know that you have been responsible for its development and particularly to know that the medical profession also realizes and appreciates what you have done.

Again my congratulations and may you continue to serve for many years to come.

Yours very truly,

K. L. Partlow, M.D.
Kenneth L. Partlow, M.D.,
President

WESTERN
UNION

SE-CA024 CGN PD=WUX CHICAGO ILL 25 1028A

ON YOUR NINETIETH BIRTHDAY MAY I ADD MY FELICITATIONS FOR YOUR LONG SERVICE TO MEDICINE AND THE COMMUNITY ONE OF THE NICE THINGS ASSOCIATED WITH TODAY WILL BE YOUR MEMORIES SHARING THEM ARE YOUR MANY FRIENDS AS A MEMBER OF THE LATTER GROUP MAY I SAY HAPPY BIRTHDAY AND BEST WISHES FOR THE YEARS TO COME

AUSTIN SMITH

PR-BOA269 DL PD=BOISE IDA 23 139P

THE ENTIRE MEMBERSHIP OF THE IDAHO STATE MEDICAL ASSOCIATION JOINS IN EXTENDING WARMEST CONGRATULATIONS AND BEST WISHES TO YOU ON YOUR 90TH BIRTHDAY. UNDER YOUR ABLE GUIDANCE NORTHWEST MEDICINE HAS BECOME AN OUTSTANDING MEDICAL PUBLICATION.

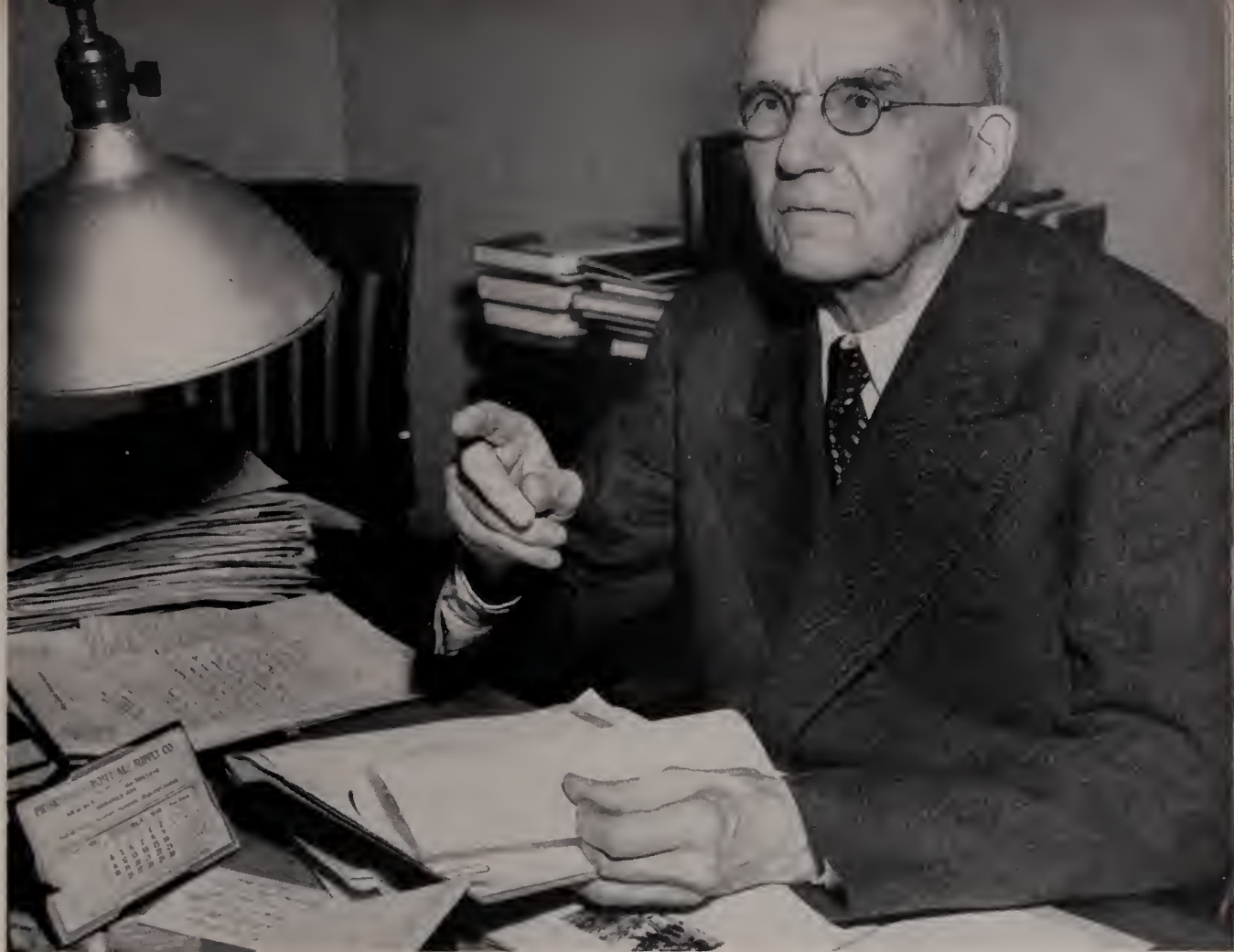
RUSSELL T SCOTT MD PRESIDENT ALFRED M POPMA MD
PRESIDENT ELECT ROBERT S MC KEAN MD SECRETARY IDAHO
STATE MEDICAL ASSN

SE-CA066 PD=WUX CHICAGO ILL 24 1217P

SINCERE CONGRATULATIONS ON YOUR NINETIETH BIRTHDAY AMERICAN MEDICINE OWES A PROFOUND DEBT OF GRATITUDE TO THE DEAN OF MEDICAL EDITORS YOU CAN BE PROUD OF A MAGNIFICENT ACHIEVEMENT

GEORGE F LULL

PR-MA387 NL PD=NEWYORK NY 16
"THE BULLETIN OF THE NEW YORK ACADEMY OF MEDICINE SENDS CORDIAL
FELICITATIONS UPON YOUR NINETIETH BIRTHDAY AND THE FIFTIETH
ANNIVERSARY OF NORTHWEST MEDICINE"
"MANLON ASHFORD EDITOR"



CLARENCE SMITH came to Seattle in 1889. It must have been a strange village to the young student, school teacher, organist and finally physician ready to hang a shingle in the new land. At twenty-eight his experience had been varied but he had one outstanding trait. He was a true New England scholar.

That mark he has left upon all that he has touched in the sixty-two years he has lived in Seattle. It has become a part of NORTHWEST MEDICINE, for the journal has been his very life for nearly fifty years. Into it he has breathed his personality and his imagination. Of it he has made a publication unique in America with a record of continuous editorship never elsewhere equalled.

Long years of toil over manuscripts and editorials have not tired his interest nor dulled his concern for the journal. Still vigorous in his views, adamant in his opinion yet flexible in acceptance of new ideas, he is the personification of the best in medical editing. He still observes regular office hours and still does the major part of manuscript preparation and editorial writing. The above photograph of Dr. Smith at his desk shows clearly the vigor and interest in his work which characterize him today.

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

Birthday Greetings

Rhode Island Medical Journal

PUBLICATION OFFICE

Dear Doctor Smith:

You are a delightful example of the fact that chronology has not necessarily much to do with age. How foolish it would be to put you in charge of a doctor who claims to be a specialist in geriatrics. Congratulations to you and to Northwest Medicine.

Sincerely,

Peter P. Chase

PETER PINEO CHASE, M.D.

Washington State Nurses Association, Inc.

514 MEDICAL ARTS BUILDING
SEATTLE 1, WASHINGTON

Dear Doctor Smith,

On behalf of professional nurses in Washington, we wish to offer you our congratulations on the anniversary of your ninetieth birthday.

We are indeed pleased that you are continuing to serve this area as Editor of "Northwest Medicine". The success of this publication is a special tribute to the foresight, determination and vigor which have so characterized your work.

It is a privilege to be permitted to pay tribute to you and your outstanding contribution in the advancement of medicine and nursing.

Sincerely yours,

Mary Ella Adams
MARY ELLA ADAMS
Executive Secretary



Washington State Medical Bureau

328 WHITE-HENRY STUART BUILDING * SEATTLE 1, WASHINGTON

Dear Doctor Smith:

We commend you on your ninetieth birthday anniversary, and wholeheartedly applaud the vigor and progress of Northwest Medicine under your editorship. Your editorials and comments have been invaluable to us and we appreciate the sincere interest you have always devoted to the problems of the State Bureau.

May you continue the experienced guidance of Northwest Medicine through many future anniversaries.

Yours very truly,

WASHINGTON STATE MEDICAL BUREAU

John Steen
JOHN STEEN, Manager

MINNESOTA MEDICINE

PUBLISHED MONTHLY BY THE

MINNESOTA STATE MEDICAL ASSOCIATION

Dear Dr. Smith:

It is with great pleasure that I respond to the opportunity of tendering my congratulations to you on the record you have achieved.

To have attained the age of ninety is in itself a distinction; to have edited Northwest Medicine for fifty years is, without a doubt, a record; to be able to continue the editorship means, I am sure, you have established a goal that youngsters like myself with a mere thirty-two years of editorship will find it difficult to attain.

May you have many more years of service to devote to the profession!

Sincerely,

MINNESOTA MEDICINE

Carl B. Drake, M.D.
Editor

To the Press. Each month Dr. Smith gathers together all material for the forthcoming issue and takes it to the plant of Western Printing Company where the journal is printed. He insists upon giving final instructions to the foreman of the print shop himself.

CONGRATULATIONS TO YOU ON YOUR 90 BIRTHDAY ANNIVERSARY AND ON YOUR CONTINUING SERVICE TO THE MEDICAL PROFESSION AND TO NORTHWEST MEDICINE.

WILLIAM F. DEVIN, MAYOR



STATE OF OREGON
EXECUTIVE DEPARTMENT
SALEM

January 24, 1951

Dear Doctor Smith:

It is a pleasure to join in extending greetings to you on your 90th birthday, which marks also your forty-ninth anniversary in the editorship of "Northwest Medicine". Friends of mine in the medical profession in this state have spoken many times of the contribution that you have made during the years of your service to the advancement of medicine in the Pacific Northwest and I know the high regard that they have for you.

Personally and officially I wish to convey my congratulations on this anniversary. It is appropriate that recognition be accorded to you for the important part that you have taken in the field of medical progress and for the excellent standards you have maintained in the publication of the professional journal.

With best wishes to you on your birthday, and with kindest personal regards, I am

Cordially yours,

Douglas McKay

PILGRIM CONGREGATIONAL CHURCH
500 BROADWAY N. SEATTLE 2, WASH.

Dear Dr. Smith:

It is both a privilege and honor to congratulate you on this occasion of your ninetieth birthday anniversary, and I speak not only on my own behalf, but also for Pilgrim Congregational Church.

We, at Pilgrim Church, honor and respect you for your long years of faithful service and interest in this local church and in the missionary reaches of our Congregational enterprise. We remember your work as organist many years ago, and your special interest in the Board of Deacons.

Let us all congratulate you on this your birthday and wish for you many more, and thank God, our Father for you and Mrs. Smith who has shared with us her life and work also unsparingly.

May God bless you both,

Most Sincerely yours,

Orval W. Jaffereau
Orval W. Jaffereau, B.A., B.D.
Minister

King County Medical Service Corporation
Congratulations on your 90th Birthday! So few men

in our profession contribute so much for so long to the welfare of mankind and to medicine.

Sincerely,

M. Shelby Jarce
M. Shelby Jarce, M.D.



State of Washington
EXECUTIVE DEPARTMENT
Olympia

January 19, 1951

Dear Dr. Smith:

May I be one of many to join in congratulating you on this, your very significant 90th birthday anniversary and to commend you for your years of service in newspaper work - particularly your excellent contributions through Northwest Medicine.

I wish I might see you personally to extend many happy returns of the day and to get inspiration from a young man of your age carrying on so vigorously and ably. I hope I may have the privilege of seeing you soon.

Very sincerely,

Arthur B. Brough
Governor

Abl:l



Arcana Lodge No. 87, B. & A. M.

Seattle, Washington
January 20, 1951

Dear Brother Smith:

It is with a great deal of interest and pride that Arcana Lodge notes that you are celebrating your 90th birthday anniversary on January 24th, and we sincerely congratulate you.

In reviewing the records of the Lodge, we find that you were made a Master Mason in Scipio Lodge No. 110, at Aurora, New York, on May 7, 1863, and that you affiliated with Arcana Lodge No. 87, in Seattle during the year 1902. You are to be congratulated upon the distinction of having held active membership in a Masonic Lodge for over 65 years, clearly demonstrating that your daily thoughts and actions over this long period of time are in accord and coincide with the great moral teachings of our Fraternity. It is with interest we again recall that the Grand Lodge of Washington recognized your achievement and has honored you with a Fifty Year Certificate and Pin for your loyalty and support to our organization, a record and distinction comparatively few men are able to achieve. Your continued active interest in the worth while things in life are clearly an indication of the spirit that has permeated your soul and directed your life and actions now for nearly a century.

Arcana Lodge and its Officers and members are proud to know that a man of your high integrity and zeal is numbered among our membership, and I have been authorized and requested by them to write this letter of congratulation to you with the sincere wish that you may enjoy many, many more birthday anniversaries in the years to come.

Very Sincerely and Fraternaly

Earl J. Beery
Earl J. Beery, Secretary



The American Journal of Surgery, Inc.

49 WEST 45TH STREET
NEW YORK

Doctor Smith :

I have learned that January 24th is the 90th birthday anniversary of your honored self. Also, that this month fine Vol. 50, No. 1 of Northwest Medicine. I'm further told that you are still performing your editorial duties with vim, vigor and enthusiasm.

On this occasion please accept my deep and sincere congratulations. You have every reason to feel proud .. in fact, vain. You have done a splendid work ; yours is a quality publication. I wish you many added years of health and contentment.

Most sincerely yours,

Thurston S. Welton
Thurston Scott Welton, M.D., Editor.

ANESTHESIOLOGY

The Journal of The American Society of Anesthesiologists, Inc.

Dear Doctor Smith:

Please accept my sincere congratulations on your 90th birthday anniversary and your long and excellent record as Editor of NORTHWEST MEDICINE--a truly remarkable achievement.

Sincerely yours,

Henry S. Ruth
Henry S. Ruth, M.D.

At the annual trustees' meeting of Northwest Medicine held January 21 at the Olympic Hotel, Seattle, members read with interest congratulatory letters and telegrams which have poured in from all over the country. Left to right: F. C. Harvey, Spokane; G. S. Bailey, Seattle; K. H. Martzloff, Portland; J. V. Straumfjord, Astoria; H. L. Hartley, Seattle, and L. A. Hopkins, Tacoma.

P2LLK247 BDA PD=PHILADELPHIA PENN 24 433P=
CONGRATULATIONS ON THIS YOUR NINETIETH BIRTHDAY AND FOR
LIFE OF DEDICATION AND ACHIEVEMENT-
L F TICE AMERICAN JOURNAL OF PHARMACY-

M.WND059 DL PD=MILWAUKEE WIS 18 123P=
=BEST WISHES FOR YOUR 90TH BIRTHDAY THE FINE QUALITY OF
NORTHWEST MEDICINE ATTESTS TO YOUR VIGOR AND ENTHUSIASM
AND MAY YOUR LEADERSHIP CONTINUE FOR MANY YEARS TO COME=
LUCIE MURPHY EDITOR AMERICAN JOURNAL OF
OCCUPATIONAL THERAPY

.CA045 PD=CHICAGO ILL 15 1150A=
CONGRATULATIONS ON YOUR 90TH BIRTHDAY ANNIVERSARY AND OUR
BEST WISHES FOR YOUR CONTINUED SUCCESS AS EDITOR OF THE
EXCELLENT JOURNAL "NORTHWEST MEDICINE"
DR JAY ARTHUR MYERS EDITOR

American IS EAST DIVISION

Dear Dr. Smith

I understand you are
This is wonderful, and
Congratulations, and

Sincerely

John M. Storm
John M. Storm
Editor

Surgery, Gyn

WITH INTERNATIONAL
OFFICIAL JOURNAL

Dr. Clarence Smith

The Editors of NW
to send their heartiest
on his 90th birthday.

Yours is a medical
and is the result of
bution to the medical
has been unsurpassed

Please convey o



Association
GO 10, ILLINOIS

... still on the job.
... can do half as well.
... more of them.

Obstetrics
F SURGERY
OF SURGEONS

... are pleased
... Clarence A. Smith
... rating its 50th volume
... enthusiasm. Its contri-
... of the United States
... one to Dr. Smith.
... merely.

... Davis
... for the Editors of
... GYNECOLOGY AND OBSTETRICS

PBB229 CGN DL PD-BALTIMORE MD 20 235P=

THE ANNALS OF INTERNAL MEDICINE OFFERS ITS BEST WISHES TO DR
CLARENCE A SMITH ON THE OCCASION OF HIS NINETIETH BIRTHDAY AND
ITS CONGRATULATIONS ON HIS VALUABLE ACCOMPLISHMENTS AS EDITOR
OF NORTHWEST MEDICINE=

ANNALS OF INTERNAL MEDICINE

SE.CA099 PD=DAG CHICAGO ILL 24 159P=

HEARTIEST CONGRATULATIONS ON YOUR 90TH BIRTHDAY. MAY THERE
BE MANY MORE=

CAREY P MCCORD MD JEAN SPECER FELTON MD EDITORS INDUSTRIAL
MEDICINE & SURGERY=



Journal of the International College of Surgeons

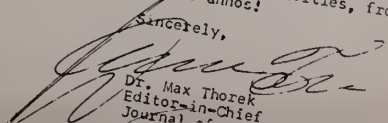
FOUNDED IN GENEVA, SWITZERLAND, 1935 - INCORPORATED IN WASHINGTON, D. C., 1940
1516 LAKE SHORE DRIVE • CHICAGO 10, ILLINOIS

My dear Dr. Smith:

It has come to our attention that you are celebrating your
90th birthday, and that you are still at the helm of your
very splendid publication. You are doing a magnificent
job on Northwest Medicine.

Permit me to congratulate you upon this occasion and I hope
that you may continue in your fine activities, from which we
have all benefited, ad multos annos!

Sincerely,



Dr. Max Thorek
Editor-in-Chief
Journal

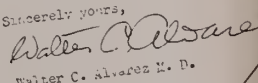
Published by
THE AMERICAN ACADEMY OF GENERAL PRACTICE
Office of the Editor
700 North Michigan Avenue • Chicago 17, Illinois

Dear Dr. Smith:

Congratulations on your 90th birthday. You
have made the years profitable ones for your
friends, your colleagues and the many readers
of your journal. I hope that you will con-
tinue in your fine work and enjoy many more
years of happiness.

Sincerely yours,





Walter C. Alvarez M. D.

AMERICAN CONGRESS OF PHYSICAL MEDICINE

Formerly American Congress of Physical Therapy
Official Publication - Archives of Physical Medicine
Formerly: Archives of Physical Therapy
Central 8-1812
30 North Michigan Avenue
Chicago 2, Illinois

Dear Doctor Smith:

The American Congress of Physical Medicine and the Arch-
ives of Physical Medicine wish to extend to you their congratulations
your long and distinguished record of service as Editor-in-Chief
Northwest Medicine on the happy occasion of your ninetieth birthday.

Sincerely yours,



Arthur L. Watkins, M.D.



Editor and Business Manager do not always agree. The photographer stole this picture of Dr. Smith addressing pointed remarks to Kirby Torrance on the necessity of increasing the size of the Journal to make room for scientific articles.

JOURNAL OF SOUTH MEDICINE AND SURGERY

Dear Dr. Smith:

... I can only voice my thanks for having been privileged to participate in the general good you have done ... A final pertinent reminder is that Cicero recorded that Masinissa, "though 90 years old, is free from unhealthy humors, and so still performs all the duties and functions of a king."

Appreciatively,

J. M. NORTHINGTON, M.D.
Editor

THE NEW ENGLAND JOURNAL OF MEDICINE

Dear Dr. Smith:

The entire editorial board of the *New England Journal of Medicine*, in session today, sends you its heartiest greeting. They congratulate you on having seen *NORTHWEST MEDICINE* nearly through its first half century and for having at last attained the status of elder statesmen. To this I add personal greetings as a reminder of our pleasant meetings in Boston and Chicago.

Most sincerely yours,

JOSEPH GARLAND, M.D.
Editor

SOUTH DAKOTA STATE MEDICAL ASSOCIATION Dear Dr. Smith:

... My heartiest congratulations and I hope that you can continue for at least ten more years. Your enthusiastic devotion to your job is another refutation of the trend of some of our modern business firms who have adopted the practice of retiring their executives at sixty or sixty-five ...

Sincerely,

R. G. MAYER, M.D.
Secretary-Treasurer

JOURNAL OF KANSAS MEDICAL SOCIETY

Dear Dr. Smith:

... I am most sure that you can lean back in your easy chair and feel that you have accomplished a mission in American medicine that few of us will ever attain ...

Sincerely,

LUCIEN R. PYLE, M.D.
Editor

AMERICAN JOURNAL OF DISEASES OF CHILDREN

Dear Dr. Smith:

... May I extend to you my congratulations and sympathies since I have been an editor for 25 years and I know what you have been up against.

Yours sincerely,

CLIFFORD G. GRULEE, M.D.

MEDICAL WOMAN'S JOURNAL

Dear Dr. Smith:

Your 90th birthday marks a remarkable achievement, particularly because of the added years you have had to serve your community and your profession ... May you continue in health and vigor for many, many more years.

Very sincerely,

ELIZABETH MASON-HOHL, M.D.
Editor-in-Chief

THE ILLINOIS MEDICAL JOURNAL SENDS OFFICIAL GREETINGS TO
YOU ON YOUR NINETIETH BIRTHDAY, AND ADDS CONGRATULATIONS
TO NORTHWEST MEDICINE WHICH HAS BEEN PRIVILEGED TO ENJOY
YOUR LOYALTY AND SERVICES THROUGH THE YEARS=
HAROLD M CAMP MD EDITOR THEODORE R VAN DELLEN ASSOCIATE
EDITOR L E HALLLEY BUSINESS MANAGER ILLINOIS
MEDICAL JOURNAL=..

K-OMA467 CGN PD=OMAHA NEBR 24 238P=
CONGRATULATIONS AND BEST WISHES FOR MANY MORE YEARS OF
GOOD EDITING=
HERMAN JAHR MD=

B-NVB060 BDA DL PD=NEWHAVEN CONN 24 1007A=
THE EDITORS OF THE YALE JOURNAL OF BIOLOGY AND MEDICINE
SEND YOU WARMEST GREETINGS ON YOUR NINTIETH BIRTHDAY=
WE ALSO SEND YOU HEARTY CONGRATULATIONS ON YOUR OUTSTANDING
ACCOMPLISHMENTS AS EDITOR OF NORTHWEST MEDICINE.
BEING EDITOR OF AN IMPORTANT MEDICAL JOURNAL FOR A HALF
CENTURY, YOU HAVE MADE A SPLENDID CONTRIBUTION TO MEDICINE=
MOST SINCERELY=
JOHN R BROBECK EDITOR=

HEARTIEST CONGRATULATIONS ON YOUR NINETIETH BIRTHDAY AND
TO VOLUME 50 NUMBER ONE NORTHWEST MEDICINE=
DR W R BROOKSHER SECY ARK MEDICAL SOCIETY=

SE-CA121 BDAY= PD=WUX CHICAGO ILL 23 342P=
THE ADVISORY COMMITTEE AND SJAD MEMBERSHIP EXTEND
HEARTIEST CONGRATULATIONS ON OCCASION OF YOUR
NINETIETH BIRTHDAY=
ALFRED J JACKSON STATE JOURNAL ADVERTISING BUREAU=

D-AUA564 BDA PD=AUSTIN TEX 17 50CP=
CONGRATULATIONS AND BEST BIRTHDAY WISHES. MAY YOUR FINE
SERVICE TO THE MEDICAL PROFESSION CONTINUE FOR MANY MORE
YEARS=
TOD BATES EDITOR TEXAS STATE JOURNAL OF MEDICINE

M-LLB420 VL PD=WUX MINNEAPOLIS MINN 15=
WE FEEL THAT IT IS PECULIARLY APPROPRIATE THAT FIVE YEAR OLD
GERIATRICS SHOULD HAVE THE OPPORTUNITY OF CONGRATULATING YOU
ON YOUR NINETIETH BIRTHDAY AND THE BEGINNING OF VOLUME 50 OF
THE JOURNAL YOU STILL EDIT SO ABLY. WE WISH YOU MANY MORE
YEARS OF HEALTH AND REWARDING USEFULNESS TO YOUR MAGAZINE
AND TO THE MEDICAL PROFESSION. THE BOND BETWEEN MINNESOTA AND
WASHINGTON AS PIONEER STATES WILL CONTINUE AND EVEN THOUGH
MAY NOT NEGOTIATE SEATTLE'S HILLS WITH FORMER SPEED WE ARE
CONFIDENT YOU WILL HAVE NO DIFFICULTY MAINTAINING THE
EDITORIAL PAGE YOU LONG AGO SET FOR YOURSELF. ACCEPT OUR
FELICITATIONS=
A E HEDBACK AND STAFF OF GERIATRICS=

PR-CDU010 22 NL PD=CPR FD MONTREAL QUE 16=
HEARTY CONGRATULATIONS ON YOUR BIRTHDAY STOP MAY YOU HAVE
CONTINUED GOOD HEALTH AND HAPPINESS IN YOUR GREAT WORK
FOR NORTH WEST MEDICINE=
HEAKINS AMERIC=

CONGRATULATIONS AND BEST WISHES YOUR ACTIVITIES AND
INSPIRATION=
R-S BALDWIN EDITOR WISCONSIN MEDICAL JOURNAL=

R-WNA604 NL PD=WINSTONSALEM NCAR 23;
BIRTHDAY GREETINGS ACROSS THE CONTINENT TO THE NESTOR
OF MEDICAL EDITORS. BEST WISHES FOR MANY HAPPY RETURNS
AND FOR MANY MORE YEARS OF USEFUL SERVICE=
WINGATE M JOHNSON EDITOR NORTH CAROLINA MEDICAL
JOURNAL=..

BF NEW ORLEANS LA JAN 18 1951
THE NEW ORLEANS MEDICAL AND SURGICAL JOURNAL TAKES GREAT PLEASURE IN
EXTENDING TO YOU FELICITATIONS AND GRATITUDE ON THE OCCASION OF YOUR
ATTAINING THE NINETIETH BIRTHDAY. WE COMMEND YOU FOR YOUR YEARS OF
LEADERSHIP AMONG THOSE WHO PROMOTE THE INTEREST OF ORGANIZED MEDICINE
THROUGH THE STATE JOURNALS. WE WISH FOR YOU MANY HAPPY RETURNS OF THE DAY
AND ANTICIPATE CONTINUATION OF THE GREAT SERVICE OF YOUR JOURNAL
P H JONES OD EDITOR NO MEDICAL & SURGICAL JOURNAL

O-DVA486 NL PD=DENVER COLO 15=
A JOURNAL TWO YEARS YOUNGER THAN NORTHWEST AND A COUPLE
OF EDITORS FORTY YEARS LESS ABLE THAN YOURSELF CONGRATULATE
BOTH OF YOU ON YOUR NOTEWORTHY ANNIVERSARIES THIS MONTH.
WE HOPE NORTHWEST MEDICINE'S NEXT FIFTY YEARS ARE AS
SUCCESSFUL AS THE FIFTY YOU HAVE GIVEN IT AND WE HOPE
YOU MAY ENJOY MANY MORE YEARS OF HEALTH AND CONTENTMENT.
OUR ENTIRE EDITORIAL BOARD SENDS KINDEST REGARDS=
DOUGLAS W MACOMER MD SCIENTIFIC EDITOR HARVEY
T SETHMAN MANAGING EDITOR ROCKY MOUNTAIN MEDICAL
JOURNAL=..

FELICITATIONS ON YOUR BIRTHDAY ANNIVERSARY AND
CONGRATULATIONS ON THE SPLENDID JOURNAL WHICH YOU HAVE
CREATED MAY YOU ROUND OUT YOUR FULL CENTURY OF ACHIEVEMENT
AS EDITOR OF NORTHWEST MEDICINE=
WALLACE M YATER MD EDITOR THEODORE WIPRUD MANAGING
EDITOR MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA=

CT-CZD134 NL PD=FA COLUMBUS OHIO 16 =
CONGRATULATIONS ON YOUR 90TH BIRTHDAY, TO NORTHWEST
MEDICINE WHICH HAD THE ADVANTAGE OF EDITORIAL EXPERIENCE
WHICH ONLY THE YEARS CAN GIVE. MAY YOU CONTINUE TO
PERFORM YOUR EDITORIAL DUTIES FOR MANY MORE YEARS WITH
THE VIGOR AND ENTHUSIASM THAT HAS ALWAYS CHARACTERIZED
YOUR WORK=
JONATHAN FORMAN MD=

WASHINGTON DC JAN 19
REACHING NINETY IN THIS ULCEROUS AGE IS AN ACHIEVEMENT. REACHING IT AS
YOU HAVE, WITHOUT LOSS OF PERCEPTION OR SENSE OF HUMOR IS AN EVEN GREATER
ONE. I JOIN YOUR FRIENDS ALL OVER THE COUNTRY IN EXTENDING HEARTY CON-
GRATULATIONS.
WILLIAM ALAN RICHARDSON EDITOR MEDICAL ECONOMICS

YOU FILL ME WITH ENVY AND INSPIRATION AT THE EXCELLENT
WORK YOU ARE DOING CONGRATULATIONS AND MANY HAPPY RETURNS.
M PIERCE RUCKER EDITOR VIRGINIA MEDICAL MONTHLY=

Birthday Greeting

Birthday Greeting

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Dear Dr. Smith:

... *The Journal of the Michigan State Medical Society* also starts its fiftieth year this month and I remember with a great deal of interest the first meeting of the Association of State Secretaries and Editors at St. Louis in 1910. I first met you at that time. I was a very young editor and was looking for hints and help which you were always gracious enough to give. Very best personal good wishes and congratulations.

Very sincerely yours,

WILFRID HAUGHEY, M.D.
Editor

CLINICAL MEDICINE

Dear Dr. Smith:

The day of your 90th birthday which also initiates the half century volume of *NORTHWEST MEDICINE* shall not pass without extending to you the best wishes of editors and publishers of *Clinical Medicine*.

Sincerely yours,

F. R. STEARNS, M.D.
Editor

JOURNAL OF INSURANCE MEDICINE

Dear Dr. Smith:

Under your editorship *NORTHWEST MEDICINE* has developed into an important medical journal from which many physicians derive information and inspiration. May I in the name of the publishers and editors of *The Journal of Insurance Medicine* extend to you our best wishes for your 90th birthday and may we express the hope that for a long time to come you will continue your fruitful editorial work.

Sincerely yours,

F. R. STEARNS, M.D.
Editor

FLORIDA MEDICAL ASSOCIATION

Dear Dr. Smith:

... It is of unusual interest to learn that you are performing your editorial duties as editor of *NORTHWEST MEDICINE* with amazing vigor and enthusiasm. It is certainly very appropriate that the February issue of *NORTHWEST MEDICINE* is dedicated to your unusual record of achievement.

Sincerely,

SHALER RICHARDSON, M.D.
Editor

MEDICAL SOCIETY OF NEW JERSEY

Dear Dr. Smith:

The Publication Committee of the Medical Society of New Jersey joins its colleagues in medical journalism in extending to *NORTHWEST MEDICINE* our heartiest congratulations on the birthday of its astonishing editor. You are the dean of us all and we wish you the best on this anniversary. The best is none too good and it couldn't happen to a nicer guy.

Cordially,

HENRY A. DAVIDSON, M.D.
Editor

QUARTERLY JOURNAL OF STUDIES ON ALCOHOL

Dear Dr. Smith:

Please accept my heartiest congratulations on the occasion of your ninetieth birthday and on the simultaneous beginning of the fiftieth volume of *NORTHWEST MEDICINE*. Your editorial direction of this Journal has made it an outstanding example among publications in its class, invaluable to the physicians of the vast region it serves and an inspiration to medical editors everywhere. I wish you many years of continued activity on behalf of medical scientific journalism.

Cordially yours,

HOWARD W. HAGGARD, M.D.
Editor

AMERICAN MEDICAL WRITERS' ASSOCIATION

Dear Doctor:

... You are setting a splendid example to all the young men in medicine, and we in middle life, too, that we not relax our efforts to protect our profession. It is fine to know that you are not only able but are willing to continue to give of your talents, so we can hand to the next generation the great heritage of medical freedom that we have received. With my very best wishes for a most joyous and healthful birthday, I am

Fraternally,

HAROLD SWANBERG, M.D., Editor,
Mississippi Valley Medical Journal

TENNESSEE STATE MEDICAL ASSOCIATION

Dear Dr. Smith:

... extend congratulations to you for your long and meritorious service in the field of medical publication. *NORTHWEST MEDICINE* has for many years set a high standard for journals of state medical associations to approach. Your activities in this field have thus been a stimulus in the field of medical publication, which has left a nation-wide mark ...

Sincerely,

R. H. KAMPMEIER, M.D.
Secretary-Editor

THE BROOKLYN HOSPITAL

Dear Dr. Smith:

... To a distinguished editor, Dr. Clarence A. Smith, the *Brooklyn Hospital Journal* extends heartiest congratulations ... Few, indeed, have had the capacity and the opportunity for such outstanding accomplishments.

Sincerely,

J. ARNOLD DEVEER, M.D.
Editor

Dear Dr. Smith:

Allow me to congratulate you on your ninetieth birthday, and please further accept my wishes for many more happy, healthful returns of the day.

Sincerely,

GERHARD AHNQUIST, M.D.

Dear Dr. Smith:

Here you come to your fourscore years and ten! I wish all of Yale-in-China might be on hand to give you both an American and a Chinese brek-ek-ek-eks for the celebration. Over there they would say

Wan-swei!

Wan-swei!

Wan-Wan-swei!

Ten thousand years to you!

I join with many in sending you affectionate greetings.

Sincerely always,

EDWARD H. HUME, M.D.
New York

Dear C. A.:

I do not know how many years I have had the pleasure of knowing you. Our contacts have been rather infrequent, but it has always seemed to me that when we would meet, we picked up the contact where it was left off previously and continued as if it had been a continuous conversation. You probably became interested in me because of your love for Dr. James B. Eagleson, with whom you know I served nine years. ... This note is to congratulate you on your 90th birthday, and in a way to offer you my sincere respect for a man who has done so much for our profession through the medium of *NORTHWEST MEDICINE* and his sound judgment of medical matters. With kind personal regards, I am

Always the same,

DONALD V. TRUEBLOOD, M.D.

Birthday Greetings

DELAWARE STATE MEDICAL JOURNAL

Dear Dr. Smith:

Hail to the Chief! It is with the utmost pride and pleasure that I send birthday greetings to you on your 90th anniversary on January 24. So far as I know you have for many years led the parade of the editors of the state medical journals, and your tenure has now reached a figure that I doubt will ever be reached again. I have been told that I am the No. 2 man in line, but I am 12 years your junior in this work, a gap that I know that I will never live long enough to bridge.

When I had luncheon with you in the A. M. A. Building in Chicago in 1948 you gave me your rules for longevity and I have never forgotten them, viz.: never smoke, never drink, keep sensible hours, get eight hours' rest each night, and "all my life I have been a one-woman man."

I know the other state editors, many of whom know you better than I, will be glad to send their greetings, but none of them will be happier in so doing than I.

May you live just as long as you want to, and be healthy and happy in so living.

Sincerely yours,

W. EDWIN BIRD, M.D.
Editor

WEST VIRGINIA MEDICAL JOURNAL

Dear Dr. Smith:

It gives me a great deal of pleasure to know that you have attained what most men only dream of—the status of a nonagenarian. It gives me much pleasure also to extend congratulations not only on attaining your chronological age but the fact that you retain so well your keen mental status and the physical ability to carry on. Many more years of life and usefulness to you is my wish for you on this, your 90th birthday.

Very sincerely yours,

WALTER E. VEST, M.D.
Editor

IOWA STATE MEDICAL SOCIETY

Dear Dr. Smith:

... If we could be half as good men at that age, as you are, we shall be very fortunate. You have done an outstanding job editing NORTHWEST MEDICINE and have brought it to the eminence it now holds. Our very best wishes to you on this happy day and may there be many more of them.

Sincerely yours,

E. M. GEORGE, M.D.
Editor

JOURNAL OF THE MEDICAL ASSOCIATION OF ALABAMA

Dear Dr. Smith:

For years—almost too many to be counted—I have known very pleasantly and to my profit the Editor-in-Chief of NORTHWEST MEDICINE. ... My congratulations to you for a very useful life and to NORTHWEST MEDICINE for the service you are rendering.

Sincerely yours,

DOUGLAS L. CANNON, M.D.
Editor-in-Chief

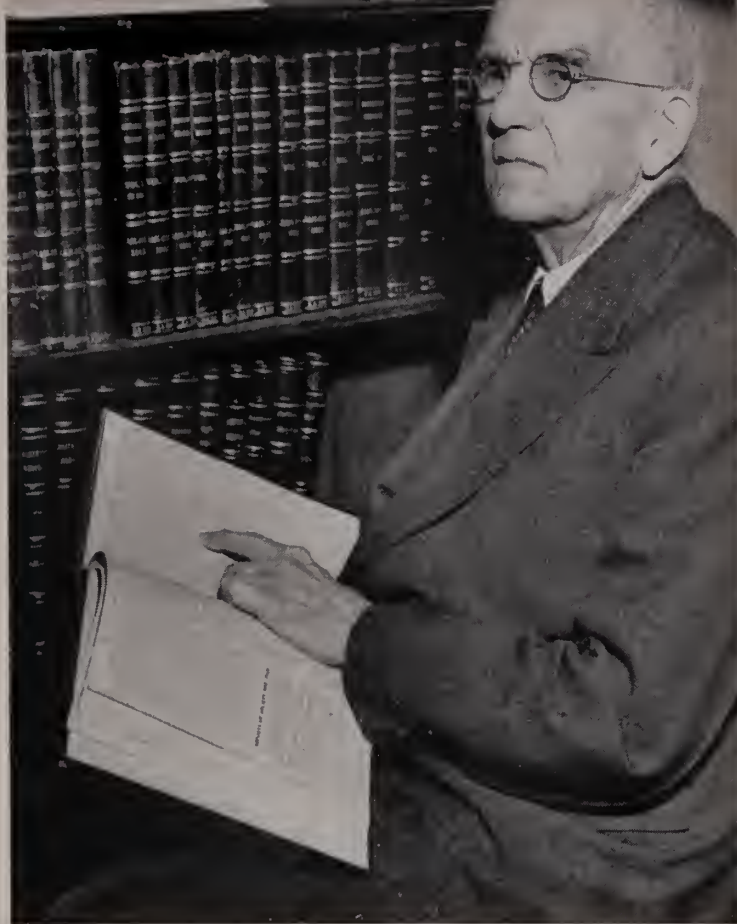
OKLAHOMA STATE MEDICAL JOURNAL

Dear Dr. Smith:

How wonderful to be able to address you on the occasion of your 90th birthday anniversary, including your long career in the editorial field. Someone has said that youth is not a matter of chronological age but that it resides in the predominance of courage over the annulling experiences of life. I have a feeling that this is true in connection with your own life. With all good wishes,

Sincerely yours,

LEWIS J. MOORMAN, M.D.
Editor-in-Chief



Pride of Record. These shelves hold forty-eight bound volumes of Northwest Medicine, visible evidence of fifty years of editing. Each cover carries the name C. A. Smith, M.D., Inside, each volume carries the record of his careful work.

MEDICAL TIMES

Dear Dr. Smith:

School, hospital, private practice, society, and the press (journals, libraries, publishers) constitute total medicine in being and in action. Greatest of all these elements is the dynamic journal section of the medical press. In the person of Dr. Clarence A. Smith his editorial colleagues hail their Dean.

Sincerely yours,

ARTHUR C. JACOBSON, M.D.
Editor

CONNECTICUT STATE MEDICAL JOURNAL

Dear Dr. Smith:

Somehow or other I seem to remember that this month marks your ninetieth milestone. If this is true I want to send you my heartiest congratulations. It is seldom that I have the honor of doing this for a nonagenarian. The old Connecticut Yankee is certainly a wonder! I hope you are feeling well and still keeping happy with your work for NORTHWEST MEDICINE. Best regards to Mrs. Smith and may you both have a very happy and prosperous year.

Sincerely yours,

STANLEY B. WELD, M.D.
Managing Editor

THE AMERICAN SURGEON

Dear Dr. Smith:

Congratulations to you upon your 90th birthday and for your useful service as Editor of NORTHWEST MEDICINE. Ninety years is a long time. How about making it one round hundred plus and may we have the honor of addressing you again on that occasion. With my personal regards to you.

IRVIN ABELL, JR., M.D.
Editor

(Continued on Page 124)



The Smiths count among their many accomplishments the establishment of a fine and successful family. Fourth generation includes these seven great-grandchildren shown with Dr. Smith as they attended the family birthday celebration at the Mercer Street home. Dr. Smith holds young Douglas McComb on his knee. Around his chair, from left to right, are: Carolyn McComb, Dixon Smith, Rosann Smith, Russell McComb, David Smith and Stephen Smith.

Dr. and Mrs. Smith in their home. Editorial accuracy prompted him to criticize this pose, for his major musical love has not been the piano but the organ. He was organist for Pilgrim Congregational Church in Seattle for many years. Photo on the piano is of son Austin, a vice-president of Carnation Company, Los Angeles.

(Continued on Page 124)



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—Editorial: Dramamine,
GP 2:27 (July) 1950



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WASHINGTON STATE MEDICAL ASSOCIATION



ANNUAL MEETING SEATTLE, 1951

President, K. L. Partlow, M.D., Olympia

Secretary, J. W. Haviland, M.D., Seattle

Executive Secretary, Mr. R. W. Neill, Seattle

Rules and Regulations of the Grievance Committee of Washington State Medical Association

In conformity with the wishes of the A. M. A. that grievance committees be set up throughout the various state organizations, the by-laws of the Washington State Medical Association were amended by the House of Delegates in September, 1950, at the Spokane meeting to provide for a grievance committee. Therefore, the Board of Trustees of the Washington State Medical Association has approved the formation of the state grievance committee to be governed by the following rules and regulations which will become effective ten days after publication in NORTHWEST MEDICINE.

1. The Committee will annually elect a chairman, a vice-chairman and a secretary from among its own members. In view of the fact that the by-laws of the Association provide that no member of the Committee is to participate in any case involving a member of his own component society the vice-chairman will preside in all cases involving a member of the chairman's society and the vice-chairman shall serve as secretary in all cases involving a member of the secretary's society. Any person against whom an accusation is made will be informed that the members of the Committee residing in his county will not be present during the Committee's deliberation of that case. However, if the accused is willing the chairman may, on occasion, instruct the committee member of the accused's society to undertake preliminary investigation, obtain information and report to the Board in order to expedite proceedings and eliminate unnecessary travel.

2. A majority of the Committee shall constitute a quorum and the affirmative vote of a majority of those present shall constitute the action of the Committee.

3. The Committee shall have the power and authority to summon members of the Association to appear before it either in connection with complaints involving the members summoned or as witnesses in cases involving other members. The failure of any member to respond to such summons without reasonable excuse shall constitute grounds for the preferring of charges of unprofessional conduct.

4. Unless, in a given case, the Committee determines that verbatim testimony should be taken, no person other than elected members of the Committee and any witness then being heard will be admitted to any part of its proceedings when the complaint is being considered.

5. Should it become necessary, in the opinion of the committee, to take verbatim testimony in any case,

the Committee will obtain the services of a court reporter. No regular employee of the Association will be requested or permitted to take notes or minutes on such matters.

6. In the event the Committee reaches the point in any investigation where the Committee feels it should file and prosecute charges against a physician before any judicial body the Committee will, before filing such charges, consult with the regularly retained attorney of the Association to determine the sufficiency of the evidence.

7. The Committee will receive written complaints from any person whether or not he or she be a physician, a member of the Association, an employee of the Association, a patient of a physician or any other person, lay or professional, and will also review *de novo* (from the beginning) any controversy or matter referred to it by the Grievance or Ethics Committee of any local component society.

8. The chairman, on receipt of each new complaint, shall cause receipt thereof to be acknowledged and shall determine whether first action on the complaint should be by the entire committee or by one or more members of the committee individually, or referred to the Grievance Committee of the local component society of the residence of the complainant, and shall forward a copy of the complaint to the agency selected.

9. The agency so designated to conduct an investigation shall, with reasonable dispatch, contact all interested parties and endeavor to arrive at an amicable settlement and shall make a written report to the Committee of the results achieved.

10. When the informal investigation outlined above does not result in the reconciliation of the complaint, or where disciplinary action is indicated, the matter shall be heard before the entire Committee, excepting any member thereof who shall likewise be a member of the same component society as the physician involved.

11. When the matter in controversy relates to the

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fee charged by a member of the Association the Committee shall, by a majority vote, determine the fee which it deems fair and proper. Failure of the member to agree to such determination of the Committee or, having agreed to the amount so fixed, failure of the member to abide by his agreement, shall constitute grounds for the preferring of charges of unprofessional conduct under the principles of ethics. Should litigation develop, the aid of members of the Association shall be withheld from the offending member and will be offered to the patient.

12. The Committee, by majority vote, may consider the case closed, may recommend settlement, or may express its advice to a member of the Association on any matter pertaining to his professional conduct, or take any other action which it deems advisable. Subject to approval of the Board of Trustees, it may recommend to the component society of which the accused physician is a member that action be taken by the Society for his expulsion, suspension or reprimand, or it may prefer charges against said physician before a criminal court or before the Director of Licenses of the State of Washington. Upon reaching a decision, both the original complainant and the physician against whom the complaint has been made will be furnished with a written statement and explanation of the final decision of the Committee as soon as possible after the Committee has completed its investigation of the case.

13. The Committee will respect the completely confidential nature of any complaint provided that any complainant unwilling to appear personally before the Committee will be given to understand that such unwillingness prejudices against the possibility of the Committee being able to make a complete investigation. Every complainant will be invited to appear before the Committee with the assurance that even the fact of his appearance before the Committee, as well as the origin of the complaint, will be kept confidential; provided, however, that should any form of prosecution result the Committee will, of necessity, reveal the names of prospective witnesses, even though these names may include that of the complainant.

14. The secretary of the Committee, in consultation with the chairman, will arrange for meetings of the Committee with such frequency as may be necessary so that investigation of each complaint is carried out with reasonable dispatch; and will notify complainants, the physician involved, and any other persons whom the Committee wishes to interview concerning meeting dates and places.

15. The secretary of the Committee shall keep appropriate and sufficient records of all of its actions and shall prepare an annual report to the House of Delegates.

Medical Notes

NEW MULTIPLE SCLEROSIS TREATMENT. St. Joseph's Hospital clinic at Tacoma, devoted to a radically new treatment of multiple sclerosis, is reaching capacity, according to Hinton D. Jonez, clinic director. He reported that *Journal of American Medical Association* has termed the treatment as the "widest concentrated attack" on the disease. The *Journal* warns that, while

"there is much to recommend it," the treatment does not promise a cure. Dr. Jonez has emphasized that no claims of cures are being made at the clinic, but the treatment has had success in bringing relief to multiple sclerosis sufferers.

CIVIL DEFENSE. Ralph R. Sachs, Richland public health officer, has been named chairman of the medical committee for the Benton-Franklin civil defense organization. He announced that emergency medical and first aid stations would be established at key points throughout the Tri-City area of Pasco, Richland and Kennewick. In charge of these centers will be D. H. Eckles, Richland; J. D. Freund, Kennewick, and J. L. Greenwell, Pasco.

MEDICAL COUNCIL MEMBERS NAMED. Governor Langlie recently appointed as members of a 12-member Council of Medical Services, as provided by Initiative 178, the following: C. R. Flood, A. H. Kelley, D. D. Dewey, E. S. Bennett, Floyd Farmer, all of Seattle; H. Kornmesser and V. M. Sim, both of Olympia; G. W. Gilbert and Mrs. Anne Pollack, both of Spokane; H. B. Henderson, Bremerton; Sister Ann Theresa, Pasco, and W. W. Eberling, Mt. Vernon.

The council will act as an advisory body to the State Health Department in the operation of the medical care program.

Society Meetings

CLALLAM COUNTY MEDICAL SOCIETY. Regular meeting was held at the Lee Hotel, Port Angeles, December 18. New officers elected for 1951 were as follows: President, H. J. Madsen, Port Angeles; vice-president, R. P. Moore, Port Angeles; secretary-treasurer, J. J. Fairshater, Port Angeles. J. C. Hay had charge of the program. Ole Jensen, Seattle, presented a paper on Carcinoma of Prostate. Gordon O'Neill, also of Seattle, gave a short talk on Treatment of Arthritis.

CLARK COUNTY MEDICAL SOCIETY. The society met at the Stage Coach Inn, Vancouver, January 2. Following a social hour and dinner, David D. DeWeese, Portland, gave a paper on Hearing Problems. With David Loree presiding, the regular business meeting followed. M. R. Mongrain and John Harrah were elected to active membership in the society.

COWLITZ COUNTY MEDICAL SOCIETY met at Hotel Monticello, Longview, January 18. Featured speaker of the program was Howard Richardson, pathologist, of University of Oregon Medical School. He talked on crime detection and the importance of cooperation between the legal and medical profession in solving crime mysteries. Slides were shown of the crimes that have been solved in the state of Oregon through the crime detection laboratories of Portland and with the cooperation of various agencies throughout the state. Following the scientific program the committee appointed by the medical society discussed their home defense program. They have now completed the details of setting up various emergency stations throughout this area in case of an enemy attack.

SNOHOMISH COUNTY MEDICAL SOCIETY met January 2 at the Monte Cristo Hotel in Everett. The program, sponsored by the American Heart Association, consisted of a discussion of courses and newer treatment of rheumatic fever. The speakers were R. A. Tidwell and L. A. Dewey, both of Seattle.

WALLA WALLA VALLEY MEDICAL SOCIETY. A dinner meeting was held at the Grand Hotel, Walla Walla, January 11. Principal speaker was William Y. Burton of the University of Oregon Medical School. He discussed the Diagnosis and Treatment of Radiation Injury Caused by Explosion of Atomic Bombs. Dr. Burton, who was among the observers of the Bikini atom bomb experiments, showed slide pictures taken there. In discussing the local angles of possible atomic bombing, Howard G. Roberts, Walla Walla, expressed the belief the public is looking more to America's medical men than ever before. Some practical observations concerning atomic bombing were outlined by J. L. Greenwell of Pasco, who attended a Seattle seminar last year. The program was arranged by C. J. Johannesson.

Personal

ALBERT B. MURPHY, Everett, was appointed to the office of assistant chief of medical services for Civilian Defense for the State of Washington. It was revealed recently. He will serve with Frank Leibly, Seattle, who will head up the medical services for the state.

PARK WEED WILLIS, who has practiced medicine in Seattle since 1892, was one of seven alumni who received honorary awards at the University of Pennsylvania's Founders' Day exercises in Philadelphia, January 20. Dr. Willis was first president and a founder of the Seattle Community Fund, forerunner of the Community Chest, and was a founder of the American College of Surgeons.

ALFRED S. STRAUSS, a leading Chicago surgeon, has been awarded the highest honor the University of Washington can give a distinguished alumnus. He has been named "Alumnus Summa Laude Dignatus" for 1951, an honor awarded each year since 1938 to an outstanding living graduate of the university. Dr. Strauss was one of the first advocates of a medical school at the University of Washington and last year established a Strauss Foundation lectureship at the school.

Locations

HOWARD G. ROBERTS, Los Angeles, has located in Walla Walla for the practice of radiology. He is associated with Carl J. Johannesson. Dr. Roberts was graduated from the University of Oregon Medical School and completed his residency in radiology at the Los Angeles General Hospital. He is a Diplomat of the American Board of Radiology.

J. SCOTT PENNYPACKER, JR., has become associated with J. M. Nelson, Paulsen Building, Spokane, in the practice of medicine and surgery. A graduate of Billings Polytechnic Institute at Billings, Mont., and the Boston University School of Medicine, he interned at Deaconess Hospital.

J. W. DEVNEY, a fellow in surgery at the Mayo Clinic, Rochester, Minn., for the past four years, has joined the staff of the Taylor-Richardson Clinic in Ellensburg as a surgeon.

MILTON SHELTON will take over the practice of the late Dr. John W. Schori and has opened offices in the

same location at Bellevue. A graduate of the College of Medical Evangelists at Loma Linda, Los Angeles, Dr. Shelton interned at Seattle General Hospital and Doctors Hospital, Seattle.

ROBERT J. HOXSEY, Wenatchee Valley Clinic surgeon and physician, has been called to active duty with the Navy. Not in the naval reserve, Dr. Hoxsey volunteered in November for active duty. He is ordered to report to the Naval Hospital at Bremerton by February 1.

WILLIAM G. BALDWIN, who together with his wife, Dr. Alpha Baldwin, set up practice in Quincy, has been called to return to the service. He has been ordered to the Lackland Air Force Base, San Antonio, Texas. Dr. Alpha Baldwin will continue practice in Quincy.

Obituaries

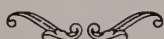
DR. IRVING E. KAVENEY, 47, Port Angeles, died January 19. He was graduated from the University of Illinois in 1930, served as member of the Clallam County Medical Bureau and on many Washington State Medical Association committees. A Fellow of the American Medical Association, he was vice-president of the state association in 1948-49 and was a trustee of the Washington State Medical Bureau.

DR. NATHAN L. THOMPSON, 78, Everett, died December 21 while visiting in Florida. He was born in Vermont and graduated from a pharmaceutical school in Philadelphia. He sold medical supplies for a number of years and became interested in medicine. He attended Northwestern University Medical School, graduating in 1904. He started his practice in Everett in 1906. A member of the American Medical Association, Dr. Thompson was twice president of Snohomish County Medical Society and a past president of Washington State Medical Association. He was a member of the Seattle and Pacific Northwest Pediatric Societies.

DR. ALBERT KNUDTSON, 76, Seattle physician and surgeon, died January 6. Born in Trondheim, Norway, Dr. Knudtson came to the United States 67 years ago. He had practiced in Seattle since 1913. He was an honorary member of the King County Medical Society and a life member of Washington State Medical Association.

DR. JOHN F. BEATTY, 62, Everett physician, died December 16. He came to Washington in 1912 after graduating the previous year from Washington University School of Medicine, St. Louis. He was a Fellow of the American Medical Association and has been an active member of the Snohomish County Medical Society.

DR. EDMUND SWEM WEST, 71, Yakima, died December 18. One of the pioneer doctors of the Yakima Valley region, Dr. West took his medical training at the Chicago Homeopathic School and his internship at Cook County Hospital in Chicago. He came to Washington in 1904. His medical affiliations included Washington State Medical Association, Yakima County Medical Society and American College of Surgeons.



State Health Council

Washington physicians have played an active part in organizing a new Washington State Health Council, a group dedicated to raising the health standards of the state through the joint efforts of those who provide and promote health services.

The Council was organized September 15, 1950, and now has nineteen member organizations.

Six professional groups were active in laying ground work for the Council, including the Washington State Medical Association, Washington State Dental Association, Washington State Nurses Association, Washington State Hospital Association, Washington State Pharmaceutical Association and the Washington State Department of Health.

These organizations have now been joined by the following active members: Professional schools in the health sciences, both at University of Washington and Washington State College; Washington Diabetes Association; Washington State Heart Association; Washington Society for Mental Hygiene; Washington State Tuberculosis Association; King County Central Blood Bank; Washington Association of Local Health Councils; Washington Society for Crippled Children and Adults; Washington Veterinary Medical Association; United Cerebral Palsy Association of Washington; Division of Vocational Rehabilitation, State Board for Vocational Education, and Washington State Public Health Association.

The Constitution of the Council states the group's aims succinctly: a. To study and define the health problems of the state and attempt to list them in the order of their importance. To further define problems which can and should be successfully solved by a state-wide program. b. To determine which problems are a responsibility of government. c. To study present and proposed government and voluntary health programs in the light of need and effi-

ciency of operation and avoidance of duplication, to the end that a well-integrated, economical, over-all health program for the people of the state will result. d. The council shall make recommendations to the proper individuals and agencies as well as to public officials as to the proper approach and handling of any health problem, but the Council shall not dictate to nor coerce member groups to abandon or alter their individual programs.

C. E. Watts is president of the Council and represents the Washington State Medical Association along with Irving Kaveney of Port Angeles. Donal R. Sparkman is vice-president, representing the Washington State Heart Association. Miss Mary Ella Adams of the Washington State Nurses' Association is secretary-treasurer. Other members of the Executive Committee are Dr. Arnold E. Stoller of the Washington State Dental Association, Mr. C. E. Morris of the Washington State Tuberculosis Association, J. A. Kahl of the Washington State Department of Health, L. E. Powers, Department of Public Health and Preventive Medicine, University of Washington; Mr. Tom Drumme, Washington State Hospital Association; Mr. C. H. Halverson, Washington State Pharmaceutical Association, and Professor Charles R. Strother, Washington State Mental Hygiene Society.

County medical societies in Washington already are participating in a number of successful local health councils. The local councils are represented in the State Health Council through their own Washington Association of Local Health Councils.

The Council has an office in the 905 Second Avenue Building in Seattle. It has employed Mr. Seymour Standish, Jr., as executive secretary. Mr. Standish formerly worked with the health education section of the Washington State Department of Health.

IDAHO STATE MEDICAL ASSOCIATION



**ANNUAL MEETING
JUNE 17-20, 1951
SUN VALLEY**

President, R. T. Scott, M.D., Lewiston

Secretary, R. S. McKean, M.D., Boise

Executive Secretary, Mr. A. L. Bird, Boise

Medical Notes

SELECTIVE SERVICE. Women doctors will not be included in the selective service registration of physicians. The announcement was made by Brig. Gen. John Walsh, director of Idaho selective service. He had previously said there was nothing in orders from Washington to exclude women doctors from the draft registration. On January 4 national headquarters published an order specifically applying the registration only to male physicians.

X-RAY PROGRAM PLANNED. The executive committee of the mass chest X-ray program, directed by Terrell O. Carver, expects to spend six to eight weeks in the Boise Valley in the near future. They will do X-ray

work at institutions, schools and industries, according to Dr. Carver. He said plans for the operation were discussed at a committee meeting in Caldwell and that word has been received that delivery of the mobile X-ray unit to be used will be about February 1.

MATHER NAMED TO NEW POSITION. John A. Mather, Boise, former physician in charge of the venereal disease clinic at the Boise-Ada county health unit, recently was named medical consultant of the unit. Mr. H. Fred Baldrige, acting director of the health unit, announced the appointment.

PHYSICIAN MARKS NINETIETH YEAR. J. H. Murray, pioneer Nampa physician, civic leader and legislator,

celebrated his ninetieth birthday on December 10 at an open house, to which his many friends were invited. The social gathering was arranged for Sunday although the exact birthday date is December 19. Dr. Murray has reached his ninetieth year in excellent physical and mental condition. He came to Nampa in 1890 and was doing limited practice up to a few years ago.

Obituary

DR. HARALD TEMPLETON NOKES, 55, a Boise physician

since 1929, died December 12 following a heart attack. He was stricken in the doctors' dressing room at a Boise hospital after performing an operation a few minutes before, hospital attendants said.

Dr. Nokes was graduated from the University of Oregon Medical School in 1927 and served his internship in Portland. He was a member of the Boise Physicians' Club, the Southwestern Idaho District Medical Society, Idaho State Medical Association and the American Medical Association.

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Postgraduate Course in General Surgery

Presented by Washington State Medical Association at Nurses' Home, King County Hospital, Seattle, March 19-23, 1951.

Sponsored by Washington State Department of Health, University of Washington School of Medicine.

MONDAY, MARCH 19

DAVID METHENY, Seattle, *Moderator*

- 8:45 a. m.—Introduction, James K. Martin, Chairman, Graduate Education and Hospital Committee, Washington State Medical Association.
- 9:00 a. m.—General Aspects of Atomic Injuries and Radiation, F. J. Leibly, Seattle.
- 10:00 a. m.—Blast Injuries, Abdominal and Thoracic, R. H. Loe, Seattle.
- 10:30 a. m.—The Treatment of Burns, H. N. Harkins, Professor of Surgery, University of Washington School of Medicine.
- 11:00 a. m.—Crush Syndrome, A. M. Sher, Instructor, Dept. of Physiology and Biophysics, University of Washington School of Medicine.
- 11:30 a. m.—Discussion Period.
- 12:00 noon—Lunch.

A. G. YOUNG, Wenatchee, *Moderator*

- 1:00 p. m.—Preoperative Preparation of Patients in Shock, P. R. Lauer, Everett.
- 1:30 p. m.—Choice of Anesthesia, J. M. MacKinnon, Seattle.
- 2:00 p. m.—Cardiorespiratory Response to Surgery, J. E. Mathwig, Seattle.
- 2:30 p. m.—Potassium Deficiency, J. F. Ramsay, Seattle.
- 3:00 p. m.—Present Trends in Treatment of Phlebotrombosis and Thrombophlebitis, C. E. MacMahon, Seattle.
- 3:30 to 4:00 p. m.—Discussion Period.

TUESDAY, MARCH 20

L. J. ROSSELLINI, Seattle, *Moderator*

- 8:30 a. m.—Clinical Pathological Conference, C. R. Jensen, Seattle.
- 9:30 a. m.—Motion Picture: Primary Cleansing, Compression and Rest Treatment of Burns.
- 10:00 a. m.—Surgery of the Breast, D. V. Trueblood, Seattle.
- 10:30 a. m.—Tube Feeding: Demonstration with Tube and Formula, V. O. Lundmark, Seattle.
- 11:00 a. m.—Discussion Period.
- 11:30 a. m.—Lunch.

J. F. LECOCQ, Seattle, *Moderator*

- 12:30 p. m.—Immediate Treatment of Compound Fractures, E. M. Burgess, Seattle.
- 1:00 p. m.—General Principles in Treatment of Fractures, I. O. McLemore, Seattle.
- 1:30 p. m.—Back Pain, L. H. Edmunds, Seattle.
- 2:00 p. m.—Shoulder Joint, Diagnosis and Treatment, J. E. Stewart for Roger Anderson, Seattle.
- 2:30 p. m.—Bursitis, Strains and Sprains, B. E. McConville, Seattle.

3:00 p. m.—Sciatica, H. L. Leavitt, Seattle.

3:30 to 4:00 p. m.—Discussion Period.

WEDNESDAY, MARCH 21

H. B. KELLOGG, Seattle, *Moderator*

- 9:00 a. m.—Diagnosis of Ano-Rectal Disease, J. H. Manning, Seattle.
- 9:30 a. m.—Office or Hospital Surgery of Common Ano-Rectal Diseases, A. M. Lewis, Seattle.
- 10:00 a. m.—Polyps of the Large Bowel and Rectum in Relation to Carcinoma, W. A. McMahon, Seattle.
- 10:30 a. m.—Dry Demonstration of Skin Grafting, D. H. Palmer, Seattle.
- 11:00 a. m.—Talc Granuloma, J. A. Duncan, Seattle.
- 11:30 a. m.—Discussion Period.
- 12:00 noon—Lunch.

A. A. WARD, Associate Professor of Neurosurgery, University of Washington School of Medicine, *Moderator*

- 1:00 p. m.—Peripheral Nerve Surgery, H. Haven, Seattle.
- 1:30 p. m.—Subdural Hematoma and Meningeal Hemorrhage, P. G. Flothow, Seattle.
- 2:00 p. m.—Care of Head Injuries, S. N. Berens, Seattle.
- 2:30 p. m.—Demonstration of Different Types of Varicose Veins and Selection of Type of Treatment, R. B. Hearne, Seattle.
- 3:00 p. m.—Surgical Therapy of Peripheral Arterial Embolism, D. K. Crystal, Seattle.
- 3:30 to 4:00 p. m.—Discussion Period.

THURSDAY, MARCH 22

R. L. ZECH, Seattle, *Moderator*

- 9:00 a. m.—Diseases Simulating the Acute Abdomen, B. P. Hullen, Seattle.
- 9:30 a. m.—Non-Malignant Obstructions of Sphincter of Oddi, B. C. Koreski, Yakima.
- 10:00 a. m.—Surgical Treatment of Diverticulitis, C. Hutchinson, Seattle.
- 10:30 a. m.—Pathology and Complications of Acute Cholecystitis, E. R. Sanderson, Seattle.
- 11:00 a. m.—Surgical Problems in Gastric Carcinoma, C. S. Stone, Seattle.
- 11:30 a. m.—The Operative Treatment of Decubitus Ulcer, E. M. Hamacher, Spokane.
- 12:00 Noon—Lunch.

J. BLACKMAN, Seattle, *Moderator*

- 1:00 p. m.—Intrathoracic Tumors, R. D. Pinkham, Seattle.
- 1:30 p. m.—Suppurative Diseases of the Lung—Bronchiectasis and Lung Abscess, W. O. Mills, Seattle.
- 2:00 p. m.—Lesions of the Esophagus, F. J. Jarvis, Seattle.
- 2:30 p. m.—Recognition and Management of Hyperthyroidism, A. J. Bowles, Seattle.
- 3:00 p. m.—Surgery of the Thyroid, B. T. King, Seattle.
- 3:30 to 4:00 p. m.—Discussion Period.

FRIDAY, MARCH 23J. K. HOLLOWAY, Seattle, *Moderator*

- 9:00 a. m.—Carcinoma of the Cecum, H. C. Keyes, Bel-
lingham.
9:30 a. m.—Carcinoma of Sigmoid, S. F. Herrmann,
Tacoma.
10:00 a. m.—Emergencies Arising During Surgery:
(a) in Biliary Surgery; (b) in Colon Sur-
gery; (c) in Gastric Surgery, J. W. Baker,
Seattle.
11:00 a. m.—Pilonidal Cyst, J. W. Read, Tacoma.
11:30 a. m.—Discussion Period.
12:00 Noon—Lunch.

E. B. SPEIR, Seattle, *Moderator*

- 1:00 p. m.—Acute Pancreatitis, Diagnosis, and Treat-
ment, E. P. Lasher, Seattle.
1:30 p. m.—Surgical Treatment of Biliary Tract Dis-
ease, G. E. Schnug, Spokane.
2:00 p. m.—Hiatus Hernia, K. A. Merendino, Associate
Professor of Surgery, University of Wash-
ington School of Medicine.
2:30 p. m.—Surgery of the Extremities in Diabetes,
M. H. Evoy, Seattle.
3:00 p. m.—Acute Tendon Injuries of the Hand, M. J.
Dirstine, Seattle.
3:30 to 4:00 p. m.—Discussion Period.

University of Oregon Medical School Spring, 1951

Internal Medicine. March 19-23. This course in Internal Medicine is under the auspices of the American College of Physicians. All physicians are eligible to attend. Application should be made directly to Mr. E. R. Loveland, Executive Secretary, American College of Physicians, 4200 Pine St., Philadelphia 4, Pa.

General Surgery. March 12-16. The course will cover common surgical conditions from the standpoint of pathogenesis, differential diagnosis, pre- and postoperative treatment, and indicated surgical procedures.

Oregon Academy of Ophthalmology and Otolaryngology. Spring Postgraduate meeting. March 26-30. Guest speakers will be Bruce Fralich, Professor of Ophthalmology at the University of Michigan Medical School; Richard Scobee, Associate Professor of Ophthalmology at Washington University, St. Louis; Theodore E. Walsh, Professor of Otolaryngology, Washington University, St. Louis; Maurice Cottle, Professor of Otolaryngology, University of Chicago Medical School. Applications are to be made directly to David D. DeWeese, Secretary of the Oregon Academy of Ophthalmology and Otolaryngology, 1216 S.W. Yamhill, Portland 5.

Electrocardiography. June 11-15. This course will be similar to those previously given in electrocardiography. Guest instructor will be Francis L. Chamberlain, Professor of Medicine, University of California.

University of Washington School of Medicine Department of Pediatrics

The Walter B. Seelye Lectureship will be given on March 9. The subject: "Metabolic Basis for the Feeding of Premature Infants," given by Harry H. Gordon at Harborview Hall, 12 noon. All interested are invited to attend.

Division of Postgraduate Medical Education

Stewart Wolf, Associate Professor of Medicine at Cornell University Medical College and coauthor of "Human Gastric Function," will speak on "Life Stress and Gastrointestinal Disease," Monday, March 19, at 5 p. m. at the Auditorium of Health Sciences Building, University of Washington School of Medicine. The lecture is open to all doctors and will be illustrated by slides and motion pictures.

Announcements of Medical Meetings

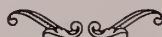
Institute on Epilepsy

THE THIRD WESTERN INSTITUTE ON EPILEPSY will be held in Salt Lake City, Utah, the week-end of June 15-17. This meeting will be of wide interest to physicians, social workers, public health nurses, employers, teachers, rehabilitation workers, state hospital personnel, educational leaders, etc. A small registration fee will be required.

Further information may be obtained by writing to Dr. Harriot Hunter, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver, Colorado, or Dr. Jean P. Davis, University of Utah, College of Medicine, Salt Lake City, Utah.

State of Oregon Examination in the Basic Sciences

The examinations will be given March 3, starting at 9 a. m., Room 306, Lincoln High School, 1620 S.W. Park Street, Portland, Oregon. Candidates for examination are expected to report at this room about 8:50 a. m. for instructions. Subjects scheduled are chemistry, hygiene, anatomy, physiology and pathology. Application blanks and general instructions may be obtained through the office of Charles D. Byrne, Secretary, State Board of Higher Education, Eugene, Oregon. Other examinations during 1951 will be given June 2, September 8 and December 1.



Correspondence

Comments on "The Indispensable General Practitioner" Editorial in the December Issue of Northwest Medicine

Explanation for the following letter:

The following letter from Mr. Charles W. Morton, Associate Editor of *The Atlantic Monthly*, is published as explanatory of what he considers as errors in the editorial in our December issue, entitled "The Indispensable General Practitioner." He mentions the incorrect first name of Dr. Smith which is regrettable. Several other statements in our editorials are also listed as being incorrect. If one were to read Dr. Smith's paper in the August issue of *The Atlantic Monthly*, he would appreciate the justifiable criticisms as published in the editorial of this journal.

In consideration of the vicious attacks which have been expressed against the medical profession of the United States and the repeated efforts of the Truman administration to introduce its socialistic program, one can readily appreciate the inspiration of the critical attack which was published in our December issue. Its purpose was to call attention to the unfortunate malevolent criticisms of our medical profession which as a body is recognized as the most progressive group of practitioners in any nation. If further justification is desired for the December editorial in this journal, it can be obtained by perusal of the above mentioned article by Dr. Caleb Smith which was published in the August issue of *The Atlantic Monthly*.

CLARENCE A. SMITH, Editor

January 7, 1951

Dear Dr. Smith:

We are obliged to you for the December issue of NORTHWEST MEDICINE and we have read its editorial comment on the article by Dr. Caleb—not "Jacob" as your editorial has it—Smith in the August *Atlantic*. We noted especially the editorial statement which acknowledges that Dr. Smith found five well-qualified general practitioners among the thirty who he had known professionally and that he found the other twenty-five inefficient and incompetent. After thus correctly stating the scope of Dr. Smith's observations, your editorial goes on to say: "Then, he makes the astounding assertion that 80 per cent of the general practitioners of this country are in the same class with these old acquaintances of his . . ."

The fact is that nowhere in his article does Dr. Smith make any such statement. On the contrary, he limits very precisely indeed the number of general practitioners with whom he finds fault, in the fifth paragraph of his article with this perfectly plain statement: "The other twenty-five general practitioners, or over 80 per cent of those I have known, I wish to discuss and analyze in some detail and, unless otherwise noted, it is to them that I shall henceforth refer when I use the term general practitioners."

In his only other reference to these 80 per cent, Dr. Smith again restricts his statement as follows: "Categorically, this has been my experience with over 80 per cent of the general practitioners I have known professionally in the past ten years."

We believe that *The Atlantic*, and Dr. Smith as well, are entitled to a correction, in your pages, of your editorial misrepresentations of his article.

Faithfully yours,

CHARLES W. MORTON, Associate Editor

A Tribute to Sun Valley

Seattle, Wash.

January 5, 1951

To John Moritz, M.D.

Sun Valley, Idaho

Dear Dr. Moritz:

I should like to express my reaction to the "Editorial" concerning the last Idaho State Medical meeting at Sun Valley which was published in the October issue of NORTHWEST MEDICINE.

I have attended the last two meetings at Sun Valley and have found the attitude of the management and the arrangements for the meetings to be quite opposed to that described in the "Editorial."

If providing one of the loveliest resorts in the world, including comfortable sleeping accommodations, superb meals and limitless recreational facilities is discourtesy or lack of management, then the Sun Valley management was justly criticized.

I believe that the absence of commercial exhibits elevates the Idaho meetings to a higher plane distinguishing them from the carnival-like atmosphere of other medical meetings. I admire the Idaho Medical Association for planning scientific meetings that are sufficiently worthwhile to be self-supporting—not dependent on the sample dispensers.

I should like to especially commend the arrangement committee for providing excellent accommodations, delicious meals including the barbecue supper, ski-tow rides, golf matches, stag party, banquet and many other pleasant features. I am sure that the arrangement of all these activities was not the result of a "public be damned" attitude.

Please accept my thank-you for the most pleasant as well as instructive experiences that the Sun Valley management has provided me during the meetings of the Idaho State Medical Association.

Very truly yours,

FRED A. ELLIS, M.D.

Regional Medical Officer

Civil Aeronautics Administration



(Continued from Page 114)

Dear Dr. Smith:

... To me for many years NORTHWEST MEDICINE has been Clarence Smith and through your leadership it came from a piddling pamphlet to a dignified organ of opinion, scientific papers, and medical news. I had no idea you were 90 years old. I thought you were about 78. "Old time is a liar" and I rejoice that you are still "on the beam" and I hope in a position to relax, in the aid of young men who are obviously loyal to you and thus to cherish in retrospect, with no apologies or regrets, the fruition of your good life and work.

Sincerely yours,

RICHARD B. DILLEHUNT, M.D.

My Dear Dr. Smith:

Neva and I had the pleasure of going out to dinner this week with Austin and Mrs. Smith, and we had a most enjoyable time. In talking with Austin yesterday, he told me that this is your birthday and that you are ninety years old. I know it is well over forty-five years since I first met you and, peculiarly, the additional years have not hung very heavily on you. You have had a most outstanding record and one that was an inspiration to those who came in contact with you. I congratulate you on the fine course that you have steered over the years and the fine heritage of memories that you will eventually leave to your family. It goes without saying that our experiences over the years always will be happy memories to me. Congratulating you on your birthday, and with every good wish to Mrs. Smith and to you, I am

Yours very sincerely,

J. F. DOUGLAS
Carnation Company**CHILDREN'S CLINIC**

Dear Dr. Smith:

Congratulations to a great gentleman and a great Doctor, and to a first class medical journal. You have been an inspiration and ideal to many of us and we will carry on to do our best. Many more years of good health and happiness with all of us.

Most respectfully,

NORMAN W. CLEIN, M.D.

**THE WESTERN JOURNAL OF SURGERY,
OBSTETRICS AND GYNECOLOGY**

Dear Dr. Hartley:

I have known Dr. Clarence A. Smith for twenty-five years. In 1929, when we decided to convert the old *Medical Sentinel* into the *Western Journal of Surgery, Obstetrics and Gynecology*, I asked Dr. Smith for his friendly advice. In the face of some general hue and cry and misunderstanding, Dr. Smith was able to understand the need and the desirability for a new journal in a different field from NORTHWEST MEDICINE. We had, therefore, the benefit of Dr. Smith's friendly counsel and have continued to have it since that time. Subsequently, for a good many years, I had the pleasure of working with Dr. Smith on the Board of Directors of NORTHWEST MEDICINE. I have been associated with him in decisions relating to various exceedingly important matters. I'm giving you this entire background to make it clear to you that I have had unusual opportunity to measure Dr. Smith's ability and to gauge the depth of his understanding. It is my pleasure at this time, on the occasion of Dr. Smith's 90th birthday anniversary, to offer him the complete tribute of my personal feeling and my personal admiration. In this I am completely joined by the staff of the *Western Journal* and the large group of Portland physicians who, like myself, have been privileged to serve under Dr. Smith in the affairs of NORTHWEST MEDICINE. I hope you will convey this message to Dr. Smith himself and, if possible, publish it as our testimonial. Clarence Smith, at age 90, has a clearer brain and a more integral personality than most men at 55.

Faithfully yours,

GOODRICH C. SCHAUFFLER, M.D.

MONTREAL NEUROLOGICAL INSTITUTE

My Dear Dr. Smith:

... I take great pleasure in sending you most hearty congratulations on behalf of the Editorial Board of *The International Journal Electroencephalography and Clinical Neurophysiology*. We have been following your work throughout the years with great interest and we are among your many colleagues who hold your work in high esteem for the great contribution you have made to NORTHWEST MEDICINE. Your continued defiance of all the laws of geriatrics has been a source of constant amazement and admiration, which few of us can hope to emulate. May we wish you many years to come, full of personal satisfaction and productive effort. As a fellow Editor, it is gratifying to know that our many headaches need not shorten our lives.

Very sincerely yours,

HERBERT H. JASPER, M.D.
Editor**THE MASON CLINIC**

Dear Dr. Smith:

I am extremely happy to be afforded this opportunity to congratulate you upon the attainment of your ninetieth birthday. This is indeed a rare privilege, extended to relatively few individuals. Particularly is this a happy event because of your keen ability to maintain interest in the various projects which you have promoted during your lifetime and to be actively associated with them. Mrs. Palmer joins me in extending our most sincere congratulations to both you and Mrs. Smith.

Sincerely yours,

LESTER J. PALMER, M.D.

Dear Dr. Smith:

It was a great pleasure to read in the paper of your 90th birthday celebration, and to know that you are still actively engaged in the publication of NORTHWEST MEDICINE. Therefore, I would like to add my heartfelt congratulations to the hundreds I know you must be receiving at this time from all of your numerous friends, acquaintances, and relatives who are wishing you well... my very best wishes for many more years of health and happiness...

Sincerely yours,

PATRICIA WEEKS

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Dear Dr. Smith:

Rarely is it permitted a man to tread this earthly vale for the span of ninety years and to retain his vigor and interest in life and his vocation as has been your privilege. Giving due credit to the achievements of medical science in prolonging life I think that in your case it has been your zest for living and an eagerness to see what lies ahead that has brought you to this anniversary of being "ninety years young." A lesser poet penned these lines about the editor which aptly fits your place in the hearts of your friends:

*To serve thy generation this thy fate
Written in water, swiftly fades thy name;
But he who loves kind does, first or late,
A work too great for fame.*

May the years ahead hold much of happiness for you and yours.

Sincerely yours,

HENRY G. SHAW

SOUTH CAROLINA MEDICAL ASSOCIATION

Dear Dr. Smith:

Please accept my sincerest congratulations, belated though they be, on your 90th birthday. You have been a real editor and a glowing inspiration to those of us who are younger in years and in medical editorial work. I just hope that when I reach your age I will have your enthusiasm and vitality, and that I will be able to look back upon as many years of service to others as you have.

Cordially yours,

JULIAN P. PRICE
Editor

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Surgery of Colon & Rectum, one week, starting March 5, April 9.
Basic Principles in General Surgery, two weeks, starting April 2.
Gallbladder Surgery, ten hours, starting April 23.
Fractures & Traumatic Surgery, two weeks, starting March 19.

GYNECOLOGY—Intensive Course, two weeks, starting February 19, March 19.
Vaginal Approach to Pelvic Surgery, one week, starting March 5, April 2.

OBSTETRICS—Intensive Course, two weeks, starting March 5, April 2.

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Electrocardiography & Heart Disease, two weeks, starting March 19.

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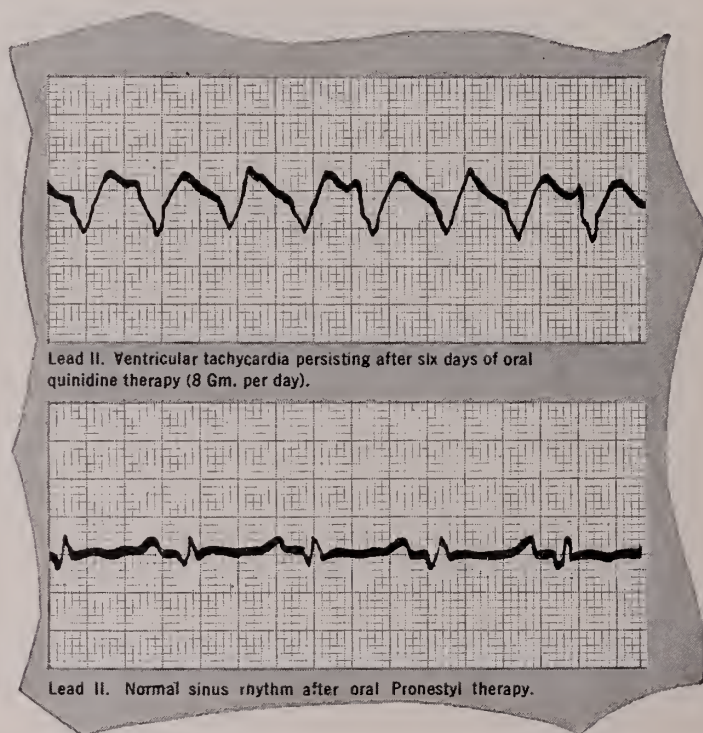
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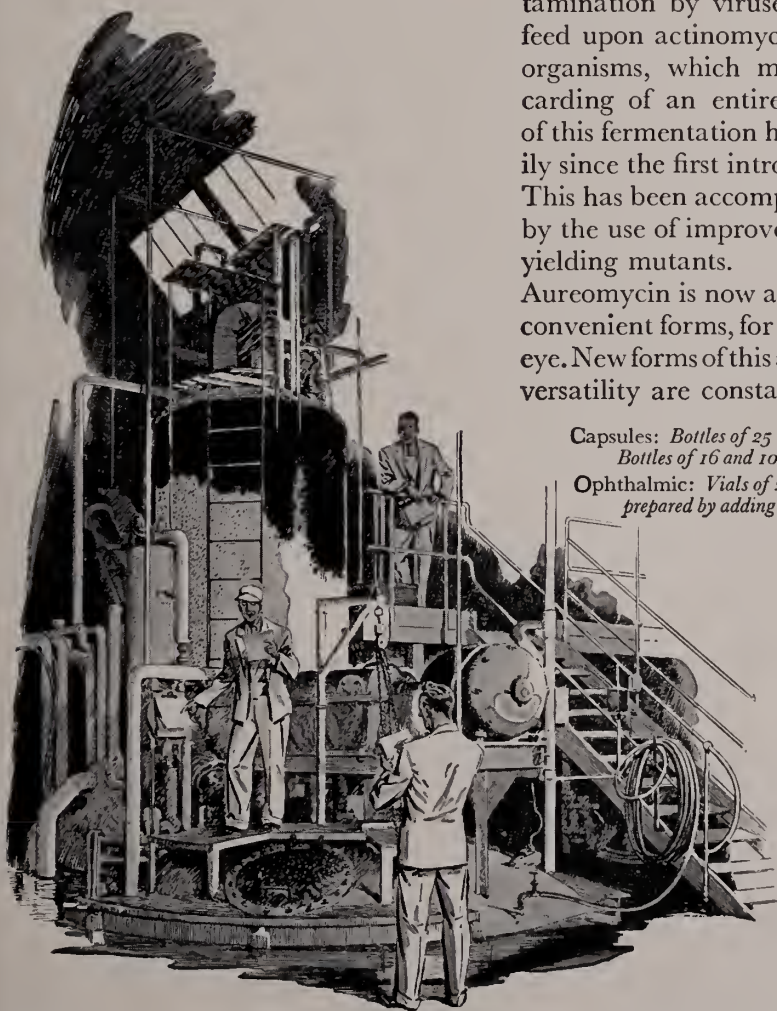
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Tacoma	Tacoma
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Olympia	Shelton
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Bellingham	Lynden
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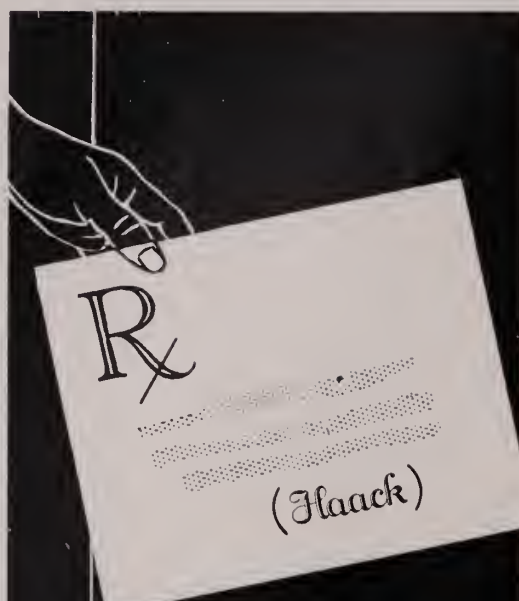
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ANNUAL SOCIETY MEETINGS

- American Medical Association**.....Atlantic City, June 11-15, 1951
- Oregon State Medical Society**.....1951
President, W. J. Weese Secretary, R. F. Miller
Ontario Portland
- Washington State Medical Association**.. Seattle—Sept. 9-12, 1951
President, K. L. Partlow Secretary, J. W. Haviland
Olympia Seattle
- Idaho State Medical Association**.....Sun Valley—June 17-20, 1951
President, R. T. Scott Secretary, R. S. McKean
Lewiston Boise
- Alaska Territorial Medical Association,**
Ketchikan—May 31-June 2, 1951
President, A. J. Schaible Secretary, W. P. Blanton
Fairbanks Juneau

PERIODICAL SOCIETY MEETINGS

NORTHWEST

- North Pacific Society of Neurology and Psychiatry,**
April 20-21, 1951—Victoria, B. C.
President, C. P. Larson Secretary, G. B. Haugen
Tacoma Portland
- North Pacific Orthopedic Society**.....Sun Valley—May, 1951
Secretary, J. K. Burton President, W. H. Goering
Boise Tacoma
- North Pacific Pediatric Society**.....Seattle—March 10
President, Gordon Matthews Secretary, S. J. Babson
Vancouver, B. C. Portland
- North Pacific Surgical Assn**...Vancouver, B. C., Nov. 16-17, 1951
President, S. F. Herrmann Secretary, J. A. Duncan
Tacoma Seattle
- Pacific Northwest Society of Pathologists**
.....April 6-7, Timberline Lodge, Mount Hood
President, C. P. Larson Secretary, G. A. C. Snyder
Tacoma Portland

OREGON

- Central Willamette Society**.....Second Thursday
President, W. W. Ball Secretary, F. R. Asbury
Corvallis Corvallis
- Oregon Academy of Ophthalmology and Otolaryngology**—Third
Tuesday, Old Heathman Hotel, Portland
President, Max Simons Secretary, R. S. Fixott
Portland Portland
- Oregon Pathologists Association, Second Wednesday**—Portland
President, V. D. Sneeden Secretary, J. E. Nohlgren
Portland Portland
- Portland Academy of Pediatrics**.....First Monday
President, S. G. Babson Secretary, Edward Rector
Portland Portland
- Portland Surgical Society**.....Last Tuesday
President, J. M. Roberts Secretary, J. W. Nadal
Portland Portland
- Southern Oregon Society**.....May, 1951—Klamath Falls
President, H. B. Currin Secretary, F. C. Adams
Klamath Falls Klamath Falls

WASHINGTON

- Puget Sound Academy of Ophthalmology and Otolaryngology**
.....Third Tuesday — Seattle or Tacoma
President, Frank Wanamaker Secretary, Willard Goff
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Seattle Seattle
- Spokane Surgical Society**.....Annual Meeting April 21, 1951
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Spokane Spokane
- Washington State Obstetrical Society**.....Seattle—April 7, 1951
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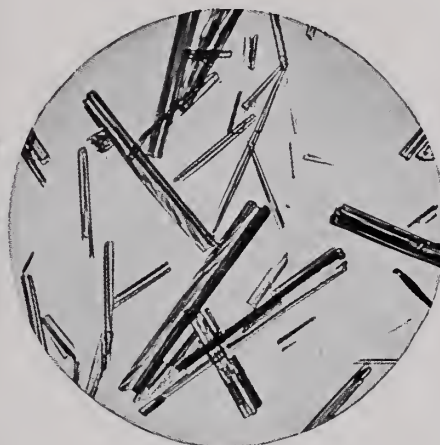
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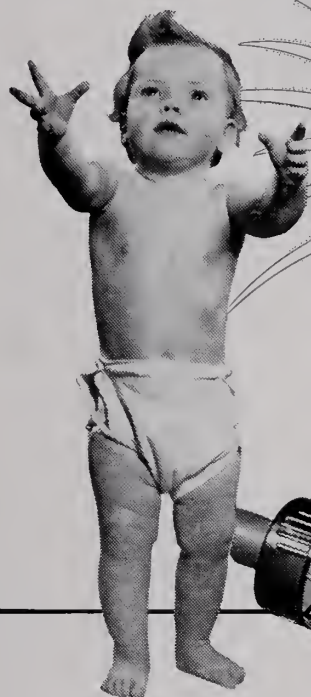
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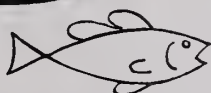
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Rickets cannot enter.....



...where the **SUN**
never sets



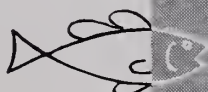
The infant or child who receives Mead's Oleum Percomorphum daily is assured of his supply of vitamin D.

No matter what the clime or season, he lives "in a land where the sun never sets," protected from the shadow of rickets.

Supplying 60,000 vitamin A units and 8,500 vitamin D units per gram, Mead's Oleum Percomorphum provides this dependable prophylaxis in small doses at low cost.

Mead's Oleum Percomorphum comes in bottles of 10 and 50 cc., and of 50 and 250 capsules. Patients appreciate the economy of the large sizes.

Mead's Oleum Percomorphum is the *original* Oleum Percomorphum product—with a background of 17 years of quality and clinical acceptance. Available in all drugstores.



When you prescribe Oleum Percomorphum
Specify

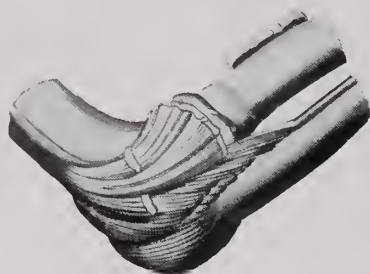
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Oleum Percomorphum

MEAD JOHNSON & CO.
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In the dictionary

"Joint" sometimes
means...



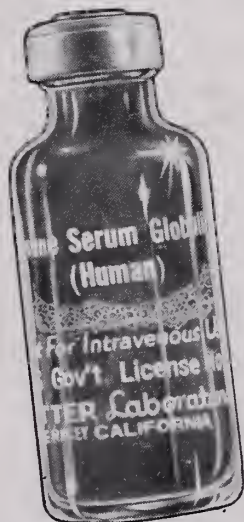
"Joint" sometimes
means...



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(human) — CUTTER
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100% venous blood



100% Venous Blood Means:

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MARCH, 1951

No. 3

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Rheumatoid Arthritis — Sherwood and Zimmerman

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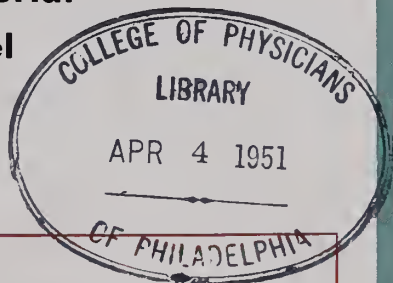
House of Delegates Meeting — Oregon Section

Ewing's Latest Marionette — Editorial

Rh Factor in Obstetrics — Sichel

Future of Medicine — Cline

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early modern plumbing, and health spas—
and *Eli Lilly and Company* had just been founded.

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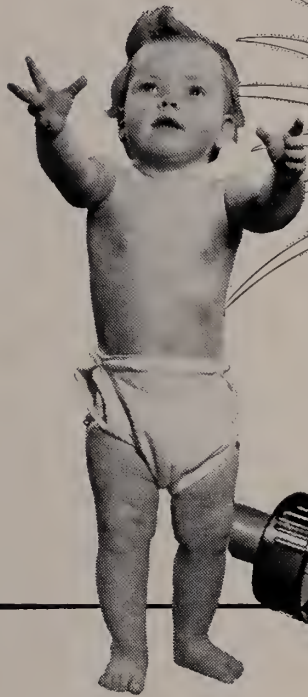
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Supplying 60,000 vitamin A units and 8,500 vitamin D units per gram, Mead's Oleum Percomorphum provides this dependable prophylaxis in small doses at low cost.

Mead's Oleum Percomorphum comes in bottles of 10 and 50 cc., and of 50 and 250 capsules. Patients appreciate the economy of the large sizes.

Mead's Oleum Percomorphum is the *original* Oleum Percomorphum product—with a background of 17 years of quality and clinical acceptance. Available in all drugstores.



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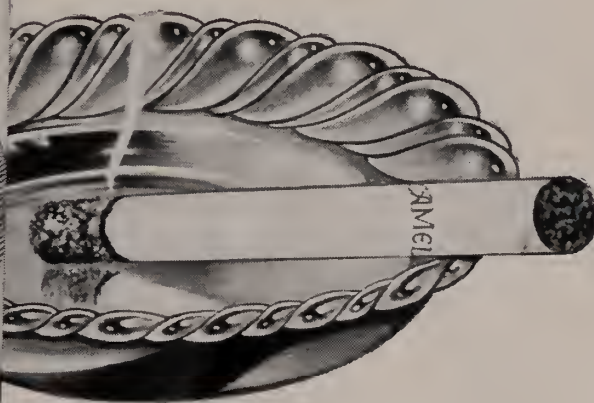
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*Hill, L. W.: New England J. Med. 242:288, 1950

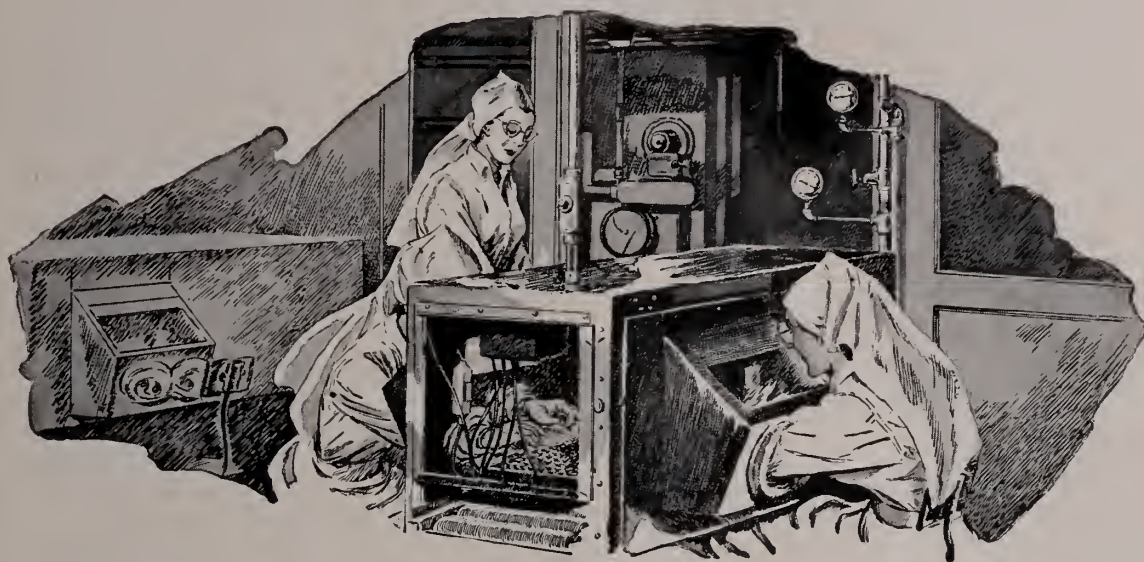
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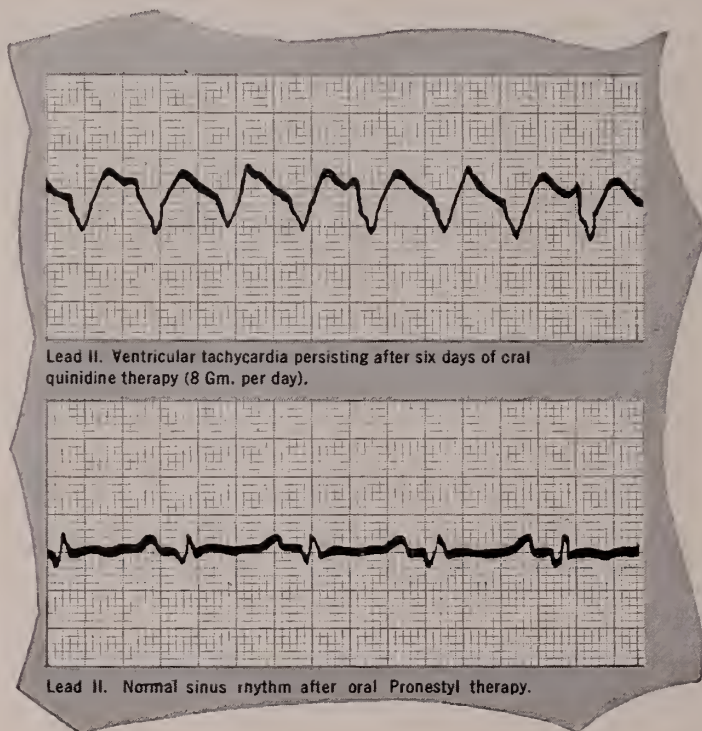
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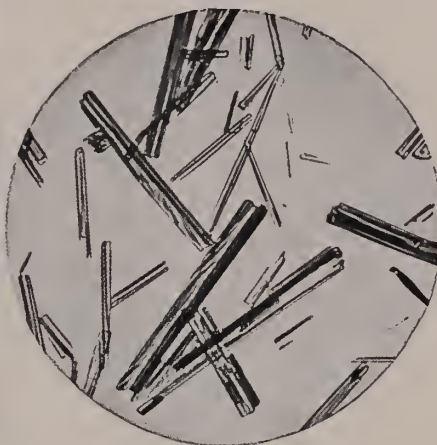
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(1) Ravdin, I. S., and Gimbel, N. S.: Protein Metabolism in Surgical Patients, J.A.M.A., 144:979 (Nov. 18) 1950.

(2) Vars, H. M., and Gurd, F. N.: Role of Dietary Protein in Experimental Liver Regeneration in Nitrogen Balance Study, Am. J. Physiol., 151:391 (Dec.) 1947.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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Hamblen, E. C.: North Carolina M. J. 7:533 (Oct.) 1946.

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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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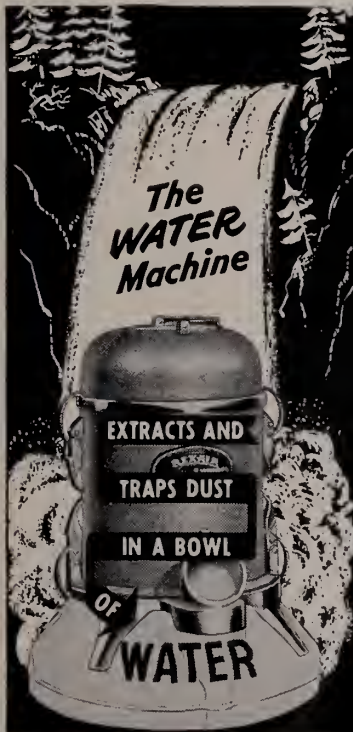
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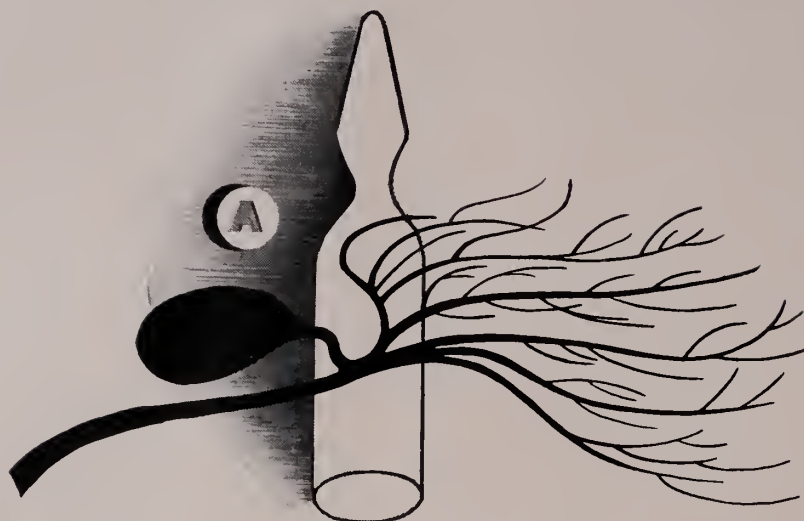
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EDITORIALS

Education

Willard C. Rappleye, dean of Columbia University's Faculty of Medicine, has sounded a note on preparation for medical education which has a good sound to those who have given serious consideration to the training not only of our medical men but youth in general. In his annual report to the president of the university, published last July, he said: "There is no such thing as a 'premedical' education. College students who plan to enter professional schools in our fields should not be regarded as premedical or predental students. Preparation for medicine should be a preparation not for medicine . . . but for life."

Dr. Rappleye feels that students should be selected for professional education on the basis of character, personality, intelligence, ability, industry, general culture, resourcefulness, maturity and evidence of a grasp of the principles underlying the sciences upon which medical study is dependent. These attributes he considers to be far more important than the single criterion of high scholastic grades.

His statement touches on one of the most serious fundamental defects in our educational system. This is the production of college and university graduates quite devoid of any ability to think from a given set of circumstances to a logical conclusion. It is all very well to urge broad education in the

arts and humanities. It is nice if our graduates are able to hold polite discourse on the life of Gauguin or the nuances of a composition by Debussy. But studies in those little niceties are not conducive to accurate thinking. This country needs people who can analyze, weigh and decide issues on the basis of logic, not polite conversation.

Indeed, such ability is indispensable to democracy, for in such an organization of society it is absolutely essential that the people can analyze, weigh and decide. It was essential to democracy as first conceived in ancient Greece, for there the people themselves formed the deliberative bodies through which they governed themselves. It is even more essential in our adaptation of democracy, where we only send representatives to sit in deliberative assembly.

Thus, Dr. Rappleye points the need for improvement in training of prospective medical men before they enter the crowded years of actual medical training. His conclusions may also be applied to education in general. For a good many years we have had evidence of seriously muddled thinking on a national scale. We need more citizens who can think from a given set of circumstances to a logical conclusion. The citizens need more scientific education.

Ewing's Latest Marionette

In the Washington section of this issue will be found a summary of the amazing Rusk report to the National Congress on Medical Education and Licensure held in Chicago last month. It is amazing because of the conclusion there will be a shortage of twenty-two thousand physicians by 1954.

Dean Turner, in his report to the faculty of the University of Washington School of Medicine, intimated that some of Dr. Rusk's statistics were prepared by the same individuals who had previously prepared figures for Oscar Ewing. He did not elaborate.

No elaboration should be necessary. To anyone

who has observed the scare tactics of Ewing the play seems a little more than just faintly familiar. Indeed it is not particularly difficult to see the strings by which that great schemer is manipulating his latest marionette.

Technic in this instance is relatively simple. Rusk waves the flag shouting danger—disaster threatens unless we have more physicians. He places great demands upon the nation's medical schools. The medical schools would not be able to meet them. They would need more money. Of course the kindly Ewing will provide all the funds necessary. What could be nicer?—for Mr. Ewing.

Public Relations—Railroad Style

Next time somebody criticizes the medical profession try this leaf out of a railroader's handbook before you get mad and criticize the critic. The railroader's guide to good public relations apparently says to first find out what is being criticized and why. Then fix it. Let the critic know that it is fixed. That is the best possible answer. Incidentally, it makes sense with the public, too.

It may be recalled that an editorial on the Idaho annual session published in October, 1950, expressed some criticism of Sun Valley management. Shortly after publication it was shown to an official of the Union Pacific Railroad at Portland. He immediately reported the matter to Omaha headquarters of the railroad. Within a few days Mr. Arthur L. Ives, general agent, passenger department, Seattle, called at the editorial office seeking information. In his pocket was a tear sheet including the critical editorial.

This was paragraph one, page one, of the handbook. Note carefully that Mr. Ives voiced no objection and evidenced no injured pride. He simply wanted the truth. He was affable, interested, sincere. He was after fact, not argument. After the interview, Mr. Ives wrote a two-page letter to his immediate superior, Mr. J. C. Cumming, general passenger agent at Portland, explaining in detail the reasons for the editorial. The report was forwarded to Omaha.

At about the same time Mr. A. G. Bloom, general passenger agent at Salt Lake City, heard about the editorial. This was of particular interest to him for Sun Valley is under his jurisdiction. He also

had read paragraph one, page one, for he immediately started looking for facts. He sent a representative to interview David McClusky, chairman of the program committee for the Idaho Association, and Mr. Armand Bird, executive secretary. Mr. Bloom himself made a special trip to Sun Valley still following paragraph one, page one. He wanted facts.

Finally, Mr. C. J. Collins, general passenger traffic manager for the entire Union Pacific System, made a special two-day stopover at Sun Valley while on an inspection trip to the West Coast. He also sought facts.

Page two of the handbook is obviously not so obvious. It concerns what was done. Of this the railroad has had nothing to say. It is intimated, however, that steps have been taken to correct errors previously unknown to officials of the line. Proof of that will no doubt appear at the next annual session of the Idaho State Medical Association which, of course, will be held at Sun Valley.

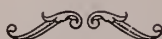
Page three apparently directs all good railroaders to make a friendly gesture to those in whose good graces they would wish to remain. If you want the story of what happened when they followed that one, read Pete the Pest Page 102, in *NORTHWEST MEDICINE* for February.

MORAL: If important officials of a great railroad take that much trouble to protect their public relations it must be pretty healthy business to: 1. When criticized, find out why; 2. correct your errors; 3. show the public your friendliness.

Forthcoming Article

Some months ago we requested preparation of an article dealing with current relationships between physicians and hospitals. The request was made to a practicing physician who is a keen student of medical economies and particularly interested in the hospital situation. Several months have elapsed since the article was first discussed. The intervening time has been used in an intensive study of the topic and preparation of the requested article. As a result, instead of an article intended to appear

in a single issue, the editors find that it will be necessary to publish the discussion in two sections in order to provide adequate treatment of the topic. The article, which bears the title, "Medicine's Problem Child, the Hospital," will therefore be published in two parts. The first will appear in the April issue. This is a careful analysis of the development of the present situation and should be read by every physician.



ORIGINAL ARTICLES

The Future of Medicine*

JOHN W. CLINE, M.D.**
SAN FRANCISCO, CALIF.

IT IS a great pleasure to be with you today and to speak to you concerning the future of medicine. In so doing, I do not wish to pose as a soothsayer or crystal gazer. The only sound method of prediction I know is deduction based upon a knowledge of history and interpretation of current trends.

There are many phases of medicine, too many to discuss in detail. Some are obviously closely related. Some appear somewhat isolated and to have little connection with others. Closer scrutiny reveals them all a part of the same structure. That which affects one, affects the whole of medicine.

One could devote considerable time to discussion of medical education, its history, current trends and probable future. One would first think of schooling but, as far as the effect upon the standards of medical care is concerned, it is inseparable from graduate training and postgraduate education.

One also could speak at length concerning research. Some of the products of research have immediate application to clinical medicine. Others which appear unrelated or remotely related will become diagnostic procedures and therapeutic methods of tomorrow. It would be possible to speculate as to when the cause or causes of cancer will be discovered and we may be enabled to deal with its manifestations on a fundamental basis rather than with our present crude methods. There are many other items which might be discussed, such as how long it will be before all the virus diseases are brought under effective chemotherapeutic or antibiotic control.

The first half of this century has been referred to as the golden age of medicine. To me it seems more probable that we are on the threshold of a much greater age. We are just beginning to understand some of the rudiments of intracellular chemistry and cellular metabolism. Each new scientific fact in these fields opens up vast vistas extending beyond our present comprehension.

In this country we have the trained scientific minds, the facilities and a medical profession with the intellectual curiosity and initiative to exploit the continuously growing body of knowledge for the benefit of the people who are our patients. This will be possible, provided medical education, re-

search and medical care remain free from governmental regimentation and the withering hand of bureaucracy. If not, the whole structure of medicine will be adversely affected and our patients will suffer.

To evaluate the present position of American medicine it is advisable to review some of the factors contributing to it. Just as the development of the embryo reflects the various stages of the evolutionary process, in the world of today are the forms of political organization which represent the stages of development of democracy. The processes which have resulted in its destruction may also be recognized in some countries.

Since its origin, the history of our country has been one of recurring political cycles of varying durations, but following similar patterns. Each has brought a swing to the left, followed by a return toward the right, but seldom if ever has the countering swing brought the pendulum to its previous position. In the course of time, therefore, there has been a gradual but somewhat irregular drift toward the left. Developments in other countries have had some influence but these cycles have resulted primarily from an American response to meet domestic conditions. We can recognize many of the resultant changes as good.

The course of the past twenty years has differed from the usual pattern in that the swing in one direction has been longer and largely has been dominated by alien ideas. Instead of being a change to meet altered domestic conditions, it has struck at the basic principles of our democracy. Until recently, few people recognized the degree of this development. The great majority of our people as yet fail to appreciate its significance and few realize that it has been brought about by the acquiescence, if not the actual connivance, of government.

The recent war accentuated the process but few if any know the degree to which the socializers, who euphemistically call themselves planners, have infiltrated the administrative branches of government. They have made unconscionable use of tax funds to propagandize the taxpayer concerning the utopian beauties of the welfare or socialist state.

They preach a philosophy of dependence upon government and have encouraged everyone with a problem to turn to government for its solution. If

*Read before fifty-eighth annual meeting, Idaho State Medical Association, Sun Valley, Idaho, Sept. 5-8, 1950.

**President-elect, American Medical Association, San Francisco, Calif.

a person has difficulties, their answer is to pass a law about them. They have bribed the taxpayer by purchasing his immediate future with his own funds while mortgaging him, his children and his grandchildren.

The result of this influence has been to induce the individual to transfer responsibilities which properly should be his to government in the search for the nebulous mirage of security. By so doing he has sacrificed much of freedom and opportunity. The stimulus to individual initiative has been reduced and that vital force which made this country great has been seriously damaged.

From the days of Bismarck, socialized medicine has been an important part of the program to make the individual dependent upon and subservient to the state. For a number of years bills to socialize medicine were introduced into the Congress but failed to strike a responsive note. It became apparent to the socializers that the independence of the American people had not been undermined sufficiently to make passage of these measures possible. They kept up their pressure and continued their propaganda awaiting a more favorable time.

A part of this process was to heap abuse upon anyone who opposed them. American medicine and its representative body became their prime targets. The proponents were aware that the average American looks upon his physician as a fine person, a good friend and a reliable source of relief in time of need. They, therefore, directed their fire principally at the American Medical Association, an impersonal, distant organization which could not command the warm loyalty the patient has for his physician. It was subjected to the most vicious, systematic campaign of vilification ever waged against a respectable organization devoted to the welfare of the people.

The American Medical Association was not prepared to meet such attacks. It had been content to do its job in the public interest quietly and without seeking credit for its accomplishments. It replied in an inept and ineffectual manner and was met by redoubled abuse. It became an ideal whipping boy.

In 1948, disregarding the official pronouncement of his party, President Truman campaigned for reelection on a personal platform promising everything to everyone, including socialized medicine. Of course, he did not call it that and he and the other advocates of such programs still make every effort to avoid the term. Thus far, restricted and artificial definitions and adroit terminology have not provided an escape from it. Any tax-supported and government-controlled system of medical care for the bulk of the population is socialized medicine, regardless of the details of the plan.

President Truman assumed his reelection to be a mandate to force the socialization of medicine. Many reporters on current affairs agreed with his estimate and the belief that such legislation was inevitable became widespread. This was the atmosphere in which the House of Delegates of the American Medical Association met in St. Louis in early December, 1948. It accepted the challenge, issued a clear statement of principles, called for a vigorous campaign against the President's program and levied an assessment upon the membership to finance it. A committee composed of officers, trustees and members of the House was created to direct the campaign.

The committee was of the opinion that the words of Edmund Burke, the English political writer of the eighteenth century and a defender of the American colonies in Parliament, were still true. These were, "People never give up their liberties except under some delusion." The problem, then, was one of education of the public concerning the harm which socialization of medicine would bring to it. The next question was how to do it. The committee, which was composed of physicians, felt the need for the services of experts in this field.

The firm of Whitaker and Baxter, which had successfully done a similar job when Governor Warren made a determined effort to force socialized medicine upon the people of California, was employed to direct the campaign. Campaign offices were opened in Chicago in January, 1949. Long conferences mapping strategy followed. An enterprise of this magnitude required careful planning, if costly mistakes were to be avoided, and such mistakes we could ill afford. On the other hand, as rapid development of the program as possible was important. Time was of the essence.

The basic plan of campaign was formulated. In February, representatives from all state associations were assembled in Chicago for the purpose of acquainting them with the plans which had been developed and of seeking their counsel and advice. The A. M. A. was to assume over-all direction, deal with matters of national scope and furnish educational material. The state associations and county societies were to undertake direction in their corresponding areas but the main reliance was to be placed in the individual physician.

Some state and county organizations have performed splendidly, some have done little, but the general average has been good. A small number of individual physicians have been openly antagonistic and some rump organizations have been troublesome, but the main obstacle has been the indifference of many of our members. This apparently stems from a failure of many physicians to appreciate the importance of the problem and the sig-

nificance of their part in it. It was true at the outset and it still is true. How to secure more active and vigorous participation in the campaign is one of the principal difficulties we have faced and still face. The success or failure of the campaign might well hinge upon this one fact. Fortunately, the country over the response has been good, even if not good enough.

The physician has great capacity to influence public opinion in matters pertaining to health and medical care. No one has as much. Real and lasting education of the public is accomplished in small groups and by personal contact. Every physician meets a number of people daily and has an unparalleled opportunity to explain the disadvantages of socialized medicine to them. Those people recognize that he holds their interests paramount and that his opinions are based upon thought and sound considerations.

The physician can obtain the support of laymen in opposing socialized medicine not only as detrimental to their medical care but also as the forerunner of other forms of socialization. Medicine cannot wage this fight alone. The cooperation of people representing other spheres of interest is essential. This becomes more apparent if one considers that, when the great majority of our people desires to have, or not to have, a particular program or law and make its wishes known, that determination is final. In the absence of public expression, good legislation may be defeated or bad legislation may be enacted as a result of the pressure of organized minority groups. Most elected representatives in Washington desire to represent their constituents faithfully within the limits of their consciences and their judgment. The remainder, who are actuated by motives of political advantage, have great respect for public opinion. Both must be kept informed of the opinions and wishes of the people at home. This is the most effective way to counter the propaganda of government employees and the threats of articulate selfish pressure groups.

The American public is, on the whole, sportsman-like and disapproves of unfair attacks upon anyone. It has a basic underlying common sense which persists in spite of the influences to which it has been subjected and possesses a sense of values which causes it, in the final analysis, to reject that which is false and accept that which is true. Therein lies the great strength of our position.

The direct appeal of physician to patient has been effective, so much so that our enemies have criticized the use of the method as unfair and unethical. The mail to members of Congress has been running more than two to one against socialized medicine. Personal letters from laymen to their Senators and Representatives carry great influence.

Similarly, endorsements of our position by local, state and national organizations are important. Multiple state and local resolutions have more weight than those of national organizations. The Congressman knows the people at home and it is their opinion he wishes. A number of Senators and Representatives already have expressed satisfaction and gratitude for the lists of resolutions furnished them. These are important considerations in making up the minds of those who are in doubt and strong backing for those who already are persuaded to our point of view.

More and more endorsements are being obtained week by week. To date approximately 11,000 such resolutions have been obtained from national, state and local organizations. The local endorsements open the way to the larger state and national bodies, and vice versa. The effect of this process has been great, but there is no limit to its ultimate influence if it is thoroughly pursued.

There has been a great change in the past year. Our campaign was just getting under way eighteen months ago. You are aware of the change of attitude of great numbers of people by reading the daily press and the periodicals. The character of news stories, articles and editorials demonstrates the trend.

In February, 1948, 80 per cent of the newspapers were editorially against socialized medicine. The propaganda of Oscar Ewing and the administration reduced the number to 74 per cent in the next year. In February of this year the figure stood at 89 per cent. This is one concrete result of our campaign.

Public opinion polls have varied in results, but an outstanding fact is that consistently a small minority has expressed itself in favor of socialized medicine. This has varied from 10 to 26 per cent in different polls. One prominent feature is that in some samples as many as 40 per cent of the people had not heard of the proposal. Another striking finding is that a majority of the lowest third in the economic scale who had an opinion concerning it were opposed to socialized medicine.

One of the weaknesses of the English medical profession was that it had no substitute for socialized medicine. There were others, such as lack of strong organization, absence of adequate financing, the weakness of leadership, secret negotiations with the government and the fact that opposition crumbled at the center and not at the periphery. Such opposition as the British Medical Association could muster was wholly negative and was based largely upon shillings and pence rather than upon principle.

From the outset the Coordinating Committee of the American Medical Association recognized that this could not be purely a negative campaign. There

are adequate reasons why any system of socialized medicine is harmful to the people who are the patients but this is not enough.

We, as physicians, know better than does any other group the economic ravages of unbudgeted serious illness. The increased cost of illness, which, though greatly exaggerated, is still high, constitutes a severe drain upon the finances of those so afflicted. The obvious and logical answer is prepaid medical care, which spreads the financial load widely enough to take the heavy burden from the shoulders of those who are ill and their families. The choice of the method lies with the people.

Should government do the job and should those who participate in the program, both patients and doctors, carry the load of a sterile and parasitic bureaucracy upon their backs in addition to submitting to the loss of freedom of choice and the loss of professional freedom, or should it be done in the American voluntary way which will preserve hospital and medical care of continuously improving standards and without the sacrifice of freedom?

The choice is as simple as that. Either we must see that those who desire to spread the cost of illness may do so through voluntary insurance programs or they will turn to government to solve their problem. The programs of the Blue Shield, Blue Cross and the insurance companies must expand and improve or government will step in with some variety of socialized medicine.

This choice points to a positive portion of our campaign. The growth of voluntary insurance in both volume and scope has been phenomenal during the past year. Our objective is to have a substantial majority of the population covered for at least the more serious aspects of illness before the end of 1950.

When one considers the great growth of such programs, the objective is by no means unattainable. In a significant sense insurance against the costs of medical care is only about ten years old. No field of insurance has ever experienced comparable growth in an equal period. Today there are more than 70,000,000 persons who have some coverage against the costs of illness. By the end of this year more than 80,000,000 should be covered.

Already American Medicine has demonstrated that it wishes to do the job, is capable of doing it and is doing it. We have long insisted upon maintaining and improving the standards of medical care and now we are demonstrating that we can and will bring that care within the easy reach of those who wish to provide it for themselves. This is the most telling argument one can have against socialized medicine with all the woes it has brought to every country which has adopted it.

Doing the job and constructing the argument,

however, are not enough. We must tell it in the highways and in the byways and figuratively shout it from the house tops. Every person in the United States must know not only that he has the finest medical care the world has ever known, but also that his doctor is bringing it to him on a basis which he easily can afford. When this has been done, and only then, can we be secure in our freedom to care for our patients in a manner which will guarantee that their best interests will be served. We must proceed with determination and steadfast resolve.

Along the way we will be in for rough treatment. Our adversaries are not gentle nor overscrupulous about their methods. Preservation of liberty is never an enterprise for timid souls or pantywaists. It requires vision, vigor and courage.

Already we have seen the police powers of the federal government unleashed against our associations and societies in a series of politically inspired inquiries designed to bring us cravenly to heel. For the first time a large, respectable and law-abiding segment of our society has courageously and indignantly struck back at this brazen misuse of the powers of government.

No longer is American Medicine on the defensive. These attacks upon us have backfired. Reliable sources inform us that the Administration wishes it had not undertaken them. The American public resents unfair and coercive persecutions but perforce these will be continued because of the loss of prestige by the socializers if they were not.

These onslaughts and the vigor of the response by American Medicine have brought the methods of a government determined to force socialism upon us into bold relief. These circumstances have served to show those in other fields the hazards which confront them as well. They now realize that American Medicine is fighting the front-line battle to save private enterprise and individual freedom. The firmness of our stand, relying upon fact and truth and the vigor of our counter-attack, have given them heart.

We no longer stand alone. Every week brings new allies who now recognize that the effort to socialize medicine is only one aspect, albeit perhaps the most important aspect, of the general drive to bring about a socialist state.

This is a battle to a finish. As the English have found out, socialism and freedom are contradictory. One flourishes and the other dies. They cannot coexist.

There is general agreement that 1950 is the year of decision. Socialism is an important issue in the Congressional elections of this year. This means that we and all others who believe in the preservation of traditional American liberties as opposed

to an all-powerful state, bent upon the regulation of people's lives, must enter into politics to an unprecedented extent. There is no partisan appeal in this statement. There are fine, sound incumbents and candidates in both parties and there are socializers and apologists for statism in both parties.

It is the individual and his convictions which count. We must know for what the candidates stand and act accordingly. The time has come when we must make our strength effective. Each one of us must exert himself to see that the character of the Congress is such that progress down the road to State Socialism is brought to a halt. We have no excuse for indifference, the feeling that we are too busy or the tendency to let others do it.

Failure to participate actively is the way to disaster. Even if we are able to forestall the adoption of socialized medicine for a time, who can envision a long-enduring island of medical freedom in a sea of socialism?

To summarize the results of the campaign to date, these have been:

1. A definite trend of public opinion against socialized medicine.

2. An increase in news and editorial comment in support of our position.

3. A general recognition that American Medicine is not the timid, inept, and impotent body it was considered by the politicians but a real force to be reckoned with. It has met successfully the full force of the Administration, including the political employment of its law-enforcing agencies, and has turned this conflict into damaging loss of prestige by the Administration.

4. The acquisition of important allies who have come to understand the hazard of our whole political, social and economic structure inherent in socialized medicine and who have been encouraged by the determined stand of the profession.

5. A growing realization that American Medicine is striving to solve and is succeeding in the solution of the medical needs of the people of this country in a realistic manner and within the existing framework of private enterprise. The phenomenal growth

and improvement of voluntary insurance are adequate proof.

6. A crystallization of Congressional opinion which has made the passage of socialized medicine as an entity impossible in this session.

7. A reorientation of our adversaries, in and out of Congress, who have placed emphasis upon the so-called "fringe bills" and sought to accomplish the same objective by piecemeal methods. Some of these measures considered certain of passage already have been defeated in the Senate and in the House.

8. Cracks beginning to appear in the ranks of our opponents. Some of them have come to doubt the wisdom and workability of the programs they previously have advocated.

We have come a long way in a short time. Medicine is definitely off the defensive, but our job is not over. Much more remains to be done.

We must continue to oppose socialized medicine as detrimental to the welfare of our people and with greater vigor than ever, but from here on the accent must be on the positive. We must emphasize what American Medicine has done and is doing for the people in the scientific improvement of the quality of medical care and in making that care more easily available to them.

Victory is within our grasp if we apply ourselves with the force and diligence we should. This means more individuals contacted and educated, the stimulation of more letters to Congress, more groups addressed, more resolutions for voluntary insurance and against socialized medicine, the education of candidates for office and effective election support of proper candidates. We must redouble our efforts.

To be lulled into complacency or to relax in our campaign would be fatal. Those who oppose us are awaiting the opportunity we would thus provide them and they still are powerful.

Our cause is just. Our position is strong. We are fighting for the medical welfare and the freedom of the people of this country. The battle is not yet won but the tide is running strongly in our favor. Should we fail to take full advantage of it, we shall have no one to blame but ourselves.



Cardiac Catheterization—A Diagnostic Aid in Congenital Heart Disease*

J. H. LEHMANN, M.D., A. D. JOHNSON, M.D., W. C. BRIDGES, M.D.,
J. MICHEL, M.D., SEATTLE, WASH., and D. M. GREEN, M.D., CHICAGO, ILL.**

IN MEDICINE, as in other fields of human endeavor, demand for a useful new method is the strongest stimulus to its discovery. Advances in surgical treatment of congenital heart disease have contributed to the need of more accurate techniques for evaluating alterations in physiology of the circulation.

Among newer procedures, the Robb and Steinberg contrast visualization of cardiac chambers and venous catheterization of the right heart have found the broadest study and application. The method, in the hands of an experienced team of physicians and technicians, has become a relatively safe and useful procedure in the study of congenital heart disease and an accurate device for calculating cardiac output. Studies of Dexter,^{1,2} Bing,^{3,4,5} Burchell⁶ and Courmand⁷ have added significantly to the understanding of hemodynamic problems caused by intracardiac or extracardiac shunts and other congenital defects.

INFORMATION GAINED BY CARDIAC CATHETERIZATION

While cardiac catheterization has its limitations, it can give very definite diagnostic aid in at least five different ways:

1. Observation, radiographically, of the catheter-tip inside of the heart yields information concerning the location and size of the cardiac chambers. Un-

usual routes of the catheter-tip can be observed.

2. Gas analysis of blood samples, obtained from different sites in the heart and great vessels, permits demonstration of admixture of oxygenated blood in the venous side or admixture of venous blood in the arterial side of the circulation.

3. Intracardiac blood pressures can be recorded by a simple water manometer or by electronic devices. These determinations are of value in identifying the different cardiac cavities. Unusual pressure changes caused by altered hemodynamics in congenital heart disease may be studied.

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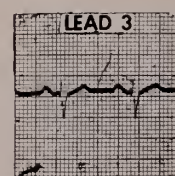
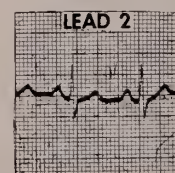
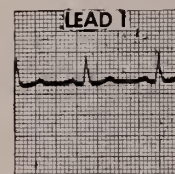
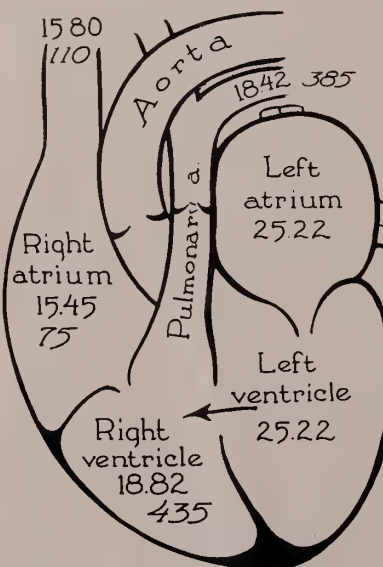
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*This study was supported in part by a grant from G. D. Searle and Co., Chicago.

**From the Department of Medicine, University of Washington, Seattle.



4. The rate of blood flow in the peripheral and pulmonic vessels and the approximate size of existing shunts can be calculated by application of the Fick principle.

5. Intracardiac electrocardiographic tracings can be taken by inserting an electrode-tipped catheter into the various cardiac chambers.

THE PRINCIPLE OF FICK

It may be of interest to explain in some detail the Fick principle as employed in calculation of cardiac output, pulmonic blood flow and blood flow in shunts.⁸ The formula of Fick postulates that cardiac output can be determined by dividing the total oxygen consumption of the body by the difference in oxygen content of arterial and venous blood. If blood from one of the peripheral arteries shows 20 volumes per cent of oxygen and well mixed blood from the venous side (found only in the right auricle, right ventricle or pulmonary artery) has an oxygen content of 15 volumes per cent it means that 5 cc. of oxygen has been removed from each 100 cc. of blood.

Total oxygen removed by all tissue in a minute's time can be determined by a basal metabolism apparatus or a spirometer. For example, 300 cc. per minute may be used by the body. Thus, 300 divided by 5 will give the total number of 100 cc. units of blood flowing from the arterial to the venous side, or the total systemic blood flow. In this case it would be 60 units or 6000 cc. of blood flowing per minute.

In the lungs oxygen goes into the blood instead of coming out. Hence the same principle enables one to measure the total blood flow through the lungs. If blood from the pulmonary artery contains 15 cc. of oxygen per 100 cc. and that from a peripheral artery (equivalent in oxygen content to the pulmonary vein) contains 20 cc., it means that 5 cc. are added to each 100 cc. of blood going through the lungs. Pulmonary blood flow in this instance would be 6000 cc. per minute.

In left to right shunt pulmonary blood flow would exceed systemic blood flow because the amount of blood flowing through the shunt is added to the normal amount of blood circulating from the right heart to the lungs. Size of the shunt can

Diagnosis: Interventricular septal defect.

Clinical Data: Male, age 23, weight 170 pounds (77 Kg.).

History: Murmur was noted in early infancy. Development was normal. No cyanosis reported. There was mild dyspnea on exertion.

Physical Examination: Well developed, no cyanosis nor clubbing.

Heart: Size: Enlarged to left. Thrills: Coarse systolic over second left interspace. Sounds: Sounds normal. Murmur: Grade IV systolic murmur, maximal in intensity over second left interspace. B. P. 122/76. Hg. 14 Gms. Rbc. 4,800,000.

ECG: Left axis deviation. Peaked P waves in lead 2.

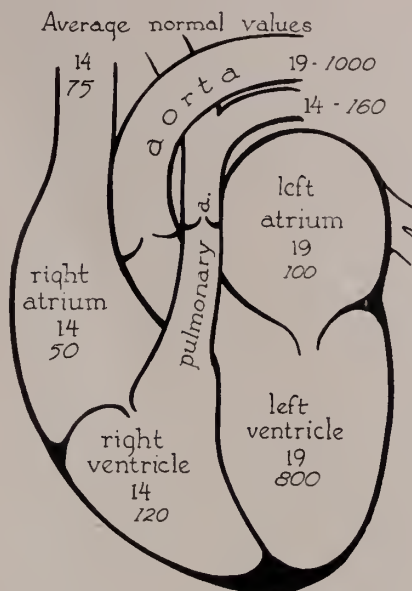


Diagram illustrating normal values obtained in cardiac catheterization. Figures in straight print in all cases represent oxygen concentration in volume per cent. Figures in italics are mean blood pressure values in millimeters of water pressure, except for cases III and VII, where figures in italics represent pressures in mms. of mercury.

be calculated by subtracting peripheral from pulmonary blood flow. In case of right to left shunt the opposite circumstances prevail. Calculation of the shunt takes into account the oxygen unsaturation of arterial blood.

METHOD

Detailed procedure for cardiac catheterization has been reported by us previously.⁹ In our study the method described by Courmand has been closely followed. It may be useful to re-emphasize a few factors most essential for a valid and safe catheterization:

1. A team of at least three physicians, skilled in this procedure.
2. Constant fluoroscopic and electrocardiographic control during manipulation of the catheter.
3. A well-trained group of technicians for immediate gas analysis of the blood samples.
4. Avertin, drug of choice, for anaesthesia of children under the age of nine.
5. Prompt discontinuance of the procedure at the first danger signal.

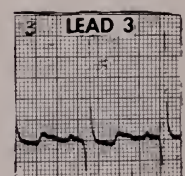
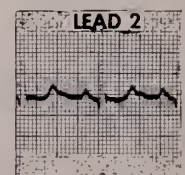
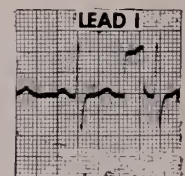
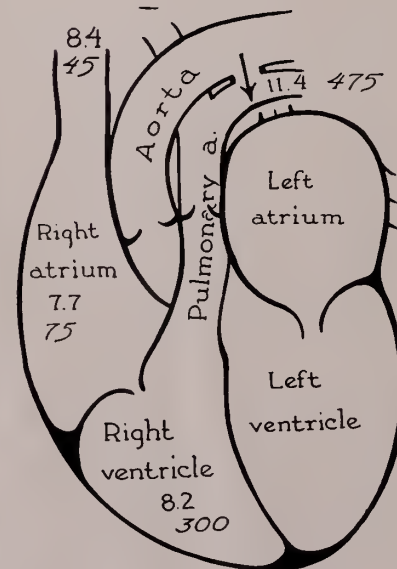
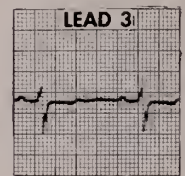
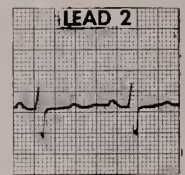
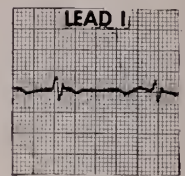
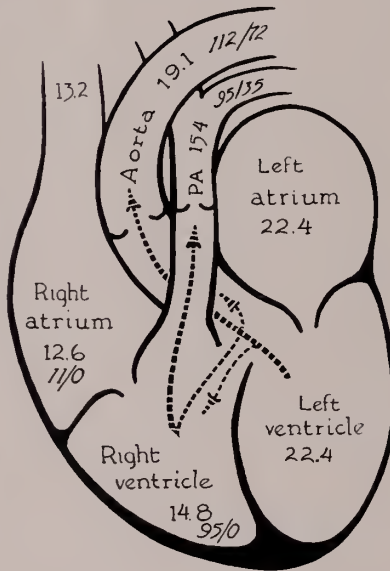
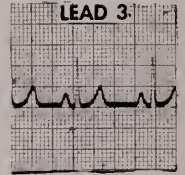
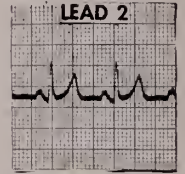
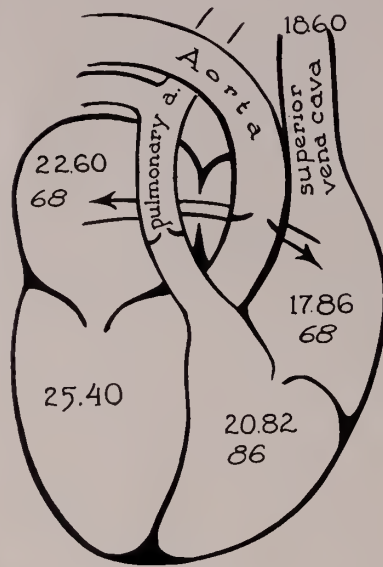
If these principles are constantly kept in mind, hazards of the method are minimal and complications usually of minor character.

CASE I

X-Ray: Heart moderately enlarged all diameters. Hilar markings increased.

Physiologic Data: Estimated blood flow: Systemic 3.7 liters/minute. Pulmonic 5.2 liters/minute. Estimated blood shunt: Left ventricle to right ventricle 1.5 liters/minute.

Comment on Physiologic Data: Cardiac catheterization proved existence of an interventricular septal defect through which arterial blood was shunted from the left ventricle to the right ventricle. There was marked elevation of blood pressure in the right ventricle and pulmonary artery due to the communication between left and right ventricles. Simple interventricular septal defect was diagnosed and no surgical treatment was advised.



CASE II

Diagnoses: Dextrocardia. Interauricular septal defect.

Clinical Data: Male, 8 years, weight 40 pounds (19.4 Kg.).

History: At birth it was noted that he was somewhat blue compared to twin brother. Marked cyanosis since age of one year. Dyspnea on moderate exertion.

Physical Examination: Marked underdevelopment, deep cyanosis. Clubbing of fingers.

Heart: Size: Enlarged to percussion. Thrill: Coarse systolic, maximum at right second interspace. Murmurs: Grade IV blowing systolic best heard over second left interspace. Transmitted to both axillae, neck vessels and to back of chest. B.P. 87/65, Hg. 19.2 Gms. Rbc. 7,000,000.

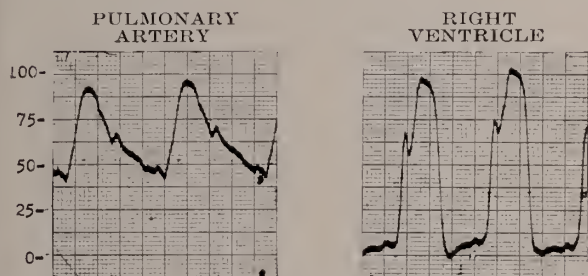
ECG: Lead one typical for dextrocardia. Peaked P waves, lead three.

X-Ray: Heart slightly enlarged, the more prominent

convexity at right border. Aorta located on right side.

Comment on Physiologic Data: After threading catheter into the superior and inferior vena cava it was advanced into the left sided auricle and thence into another chamber, presumably the right sided auricle. This fact was confirmed by high oxygenation of the sample obtained from the latter side. On further manipulation, the catheter was introduced into the left sided ventricle and from there withdrawn again into the left sided auricle. Diagnosis of dextrocardia, apparent from ECG tracings, was thus confirmed. Catheterization gave additional data which suggested existence of a wide interauricular septal defect. It must be postulated that direction of the shunt was predominately from the venous to the arterial side, thus causing the cyanosis. A single auricle (cor triloculare) could also explain this cyanosis.

CASE III



Blood pressure tracings taken by electromanometer with catheter tip in pulmonary artery and right ventricle.

Diagnosis: Eisenmenger Complex.

Clinical Data: Male, 31 years, weight 148 pounds (70 Kg.).

History: Murmur was noted in early childhood. During the last year he suffered two separate bouts of hemoptysis. No cyanosis nor clubbing.

Physical Examination: Well developed, well nourished male.

Heart: Size: Slightly enlarged on percussion. Sounds: Normal except accentuation of second pulmonic sound. Murmur: Grade II systolic murmur third left interspace. B.P. 112/72, Hg. 16.7 Gms.

ECG: Right bundle branch block with regular sinus mechanism.

X-Ray: Marked prominence of pulmonary artery. Remainder of heart silhouette within normal limits. Hilar areas and vascular markings increased.

Physiologic Data: Arterial oxygen saturation: While breathing room air 85.3 per cent. While breathing 100 per cent oxygen 87.1 per cent. Oxygen consumption 260 cc/min. Estimated blood flow: Systemic 3.9 liters/min. Pulmonic 4.5 liters/min. Estimated blood shunt: Flow from left ventricle to right ventricle and pulmonary artery 1.5 liters/min. Flow from right ventricle to aorta 0.8 liters/min.

Comments on Physiologic Data: The study demonstrated shunt from the left ventricle into the right ventricle, indicative of interventricular septal defect. There was also oxygen unsaturation of arterial blood, evidence of a shunt of venous blood from the right ventricle into the aorta overriding the interventricular septal defect. This type of reciprocal shunt may be observed in the tetralogy of Fallot and Eisenmenger Complex. It also conceivably may occur in simple interventricular defect. The large pulmonary artery visualized on X-ray eliminates the diagnosis of simple interventricular septal defect. Tetralogy of Fallot can be definitely ruled out by high pressure existent in the pulmonary artery as well as increased vascular markings in the lung fields. Diagnosis of Eisenmenger Complex seems to be well supported by the reciprocal shunt, the oxygen unsaturation of the arterial blood and the unusually high pressure values in the right ventricle and pulmonary artery.

CASE IV

Diagnosis: Patent ductus arteriosus.

Clinical Data: Male, 20 years, weight 119 pounds (54 Kg.).

History: Murmur was noted in early infancy. Physical development was quite normal. Exercise tolerance moderately impaired.

Physical Examination: A slender adolescent. No cyanosis nor clubbing. Some dyspnea on moderate exercise.

Heart: Size: Markedly enlarged to percussion. Thrill: Systolic, maximal at second left interspace. Murmur: Rough machinery type over precordium, transmitted to axilla and neck vessels. B.P. 160/40, Hg. 14 Gms. Rbc. 5,300,000.

ECG: Widened QRS complexes, depressed ST segments in lead two and three.

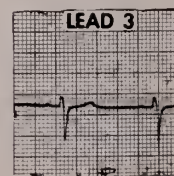
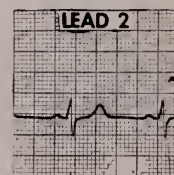
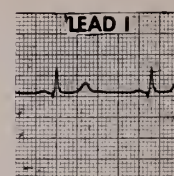
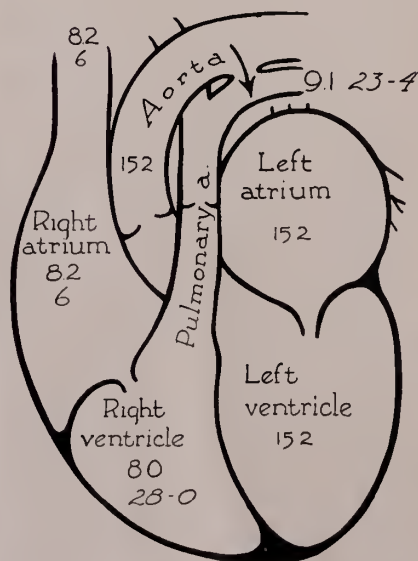
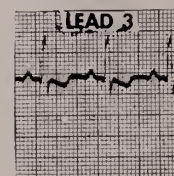
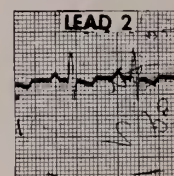
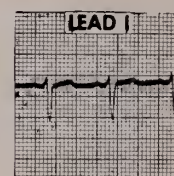
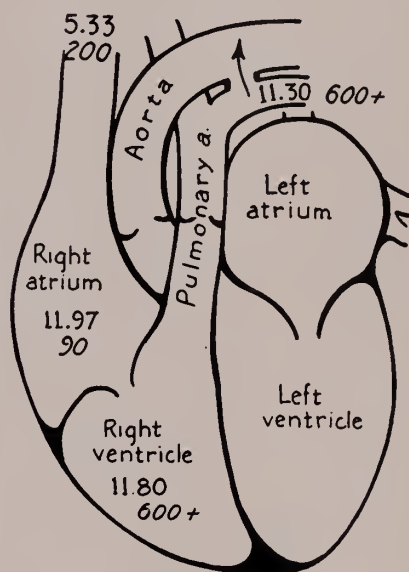
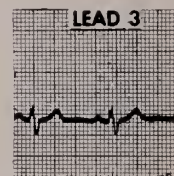
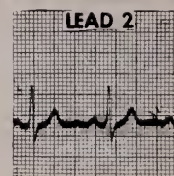
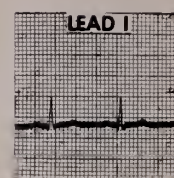
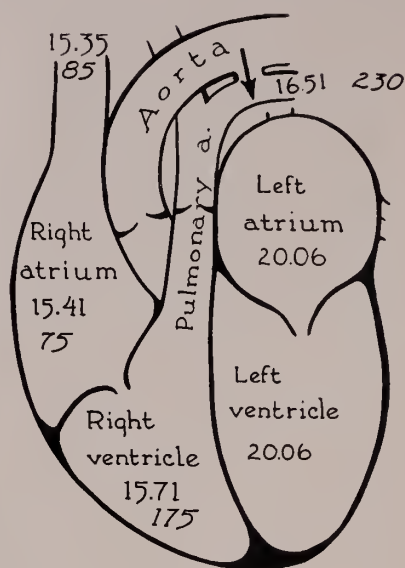
X-Ray: Marked enlargement, especially of left ventricle. Pulmonary artery widened. Hilar dance observed. Marked congestion existed throughout both

lung fields.

Comment on Physiologic Data: Patent ductus arteriosus was suspected from the typical heart murmur and thrill, the wide pulse pressure and X-ray findings. Diagnosis was confirmed with certainty by cardiac catheterization. Oxygen concentration of the sample aspirated from the pulmonary artery was markedly increased above those obtained from the right ventricle and right auricle. This finding established existence of left to right shunt between the aorta and pulmonary artery.

Operative Findings: Short patent ductus, 0.7 cm. in diameter and about 1.5 cm. in length. It was divided between two Pott's clamps. Ends were closed with interrupted silk sutures. Murmur disappeared completely.

Follow-Up Examination: Sixty days. B.P. 106/80. Patient had gained twenty pounds and had observed marked increase in exercise tolerance. There was no murmur nor thrill.



CASE V

Diagnosis: Patent ductus arteriosus.

Clinical Data: Male, 22 years, weight 155 pounds (70.2 Kg.).

History: Normal development during childhood. He served as an infantryman during World War II. Murmur was noted at routine physical examination while entering a university. He had complained of fatigue after sustained effort and dull aching pain in the chest near the left sternal border.

Physical Examination: No unusual findings.

Heart: Size: Not enlarged. Thrills: None. Murmur: Grade III continued systolic best heard over second left interspace. A short Grade I diastolic over left precordium. Systolic murmur audible also in the back. Sounds: Second aortic sound exceeded second pulmonic.

ECG: Normal.

X-Ray: Cardiac shadow not enlarged. Pulmonary vessels not prominent.

CASE VI

Diagnoses: Patent ductus arteriosus with cyanosis. Advanced pulmonary arteriosclerosis. Pulmonary hypertension.

Clinical Data: Female, 18 years, weight 92 pounds (41.7 Kg.).

History: Murmur first noted at four weeks. Cyanosis appeared at five years. Steadily decreasing exercise tolerance made her stop school at age fifteen. Marked dyspnea one year.

Physical Examination: Moderate underdevelopment. Cyanosis deep, more marked over upper part of body. Moderate clubbing, pretibial edema. Numerous bubbling rales both lung bases.

Heart: Size: Enlarged to percussion. Thrill: Coarse systolic at apex. Sounds: Second pulmonic sound increased. Murmurs: Harsh Grade IV systolic maximal intensity at apex. Also Grade I diastolic best heard over upper sternum. B.P. 104/54. Hg. 15.2 Gm. Rbc. 7,000,000. Hematocrit 57 mm. Venous pressure: 136 mm.

ECG: Marked right axis deviation and right ventricular hypertrophy.

X-Ray: Generalized cardiac enlargement especially of right heart. Pulmonary artery moderately widened. Vascular engorgement noted in lung field.

Comment on Physiologic Data: Catheterization studies supplied the following additional information. Oxygen saturation of the blood was higher in the right auricle than in the superior vena cava and remained at the same level in the right ventricle and pulmonary artery. Pressures in both right ventricle and pulmonary artery were so high they could not be accurately measured with equipment available but approximated or exceeded mean arterial pressures. Patent ductus arteriosus with marked pulmonary hypertension and regurgitation through an incom-

CASE VII

Diagnoses: Patent ductus arteriosus. Pregnancy.

Clinical Data: Female, 24 years, primipara at third month of gestation.

History: Murmur first noticed at age 12. Frequent sore throats during childhood and several episodes migratory joint swellings, last one at age 15. No history of cyanosis but moderate decreased exercise tolerance.

Physical Examination: Normally developed female with typical findings of first trimester pregnancy.

Heart: Size: Slightly enlarged to left. Thrills: Coarse systolic at second left interspace. Sounds: Second aortic sound greater than second pulmonic. Murmurs: Machinery type over precordium. Maximal intensity second left interspace. Systolic component transmitted to left axilla. B.P. 120/58. Hg. 11.2 Gms.

ECG: Moderate left axis deviation.

X-Ray: Heart silhouette moderately enlarged, pul-

Physiologic Data: Estimated blood flow: Systemic 8.20 liters/minute. Pulmonary, 13.40 liters/minute. Estimated blood shunt: Aorta to pulmonary artery 5.20 liters/minute.

Comments on Physiologic Data: Significant increase of oxygen saturation in pulmonary artery over right ventricle. This, in addition to clinical findings, was compatible with diagnosis of patent ductus.

Operative Findings: September 10, 1949. Patent ductus arteriosus, about 8 mm. in length and approximately 7 mm. in diameter. Ligated by two ties, 3 mm. apart. Not severed.

Follow-Up: Sixty days. B.P. 118/68. Grade I diastolic murmur best heard over apex. Patient well and had no complaints referable to heart. Origin of the diastolic murmur is open to conjecture. It may be postulated that an additional and undiagnosed cardiac defect gives rise to this murmur. However, recanalization of the ductus, which was only ligated and not severed, cannot be entirely ruled out.

petent pulmonary valve could explain these findings. It was also postulated that an interatrial septum defect combined with pulmonary hypertension existed.

Follow-Up Course: Surgical intervention was contraindicated due to extreme cardiac decompensation. The patient died six weeks after catheterization with signs of cardiac decompensation and recent cerebrovascular accident.

Post-Mortem Findings: Large patent ductus, about 0.5 cm. in diameter, connected the pulmonary artery and the aorta just beyond the left subclavian artery. The right auricle and ventricle were markedly dilated. The pulmonary artery exhibited a fusiform widening. Section of pulmonary vessels showed marked arteriosclerotic changes. Many smaller pulmonary vessels demonstrated complete occlusion. There was a cerebral infarct in the right hemisphere.

Comments: Post-mortem findings clearly explained the otherwise puzzling results of cardiac catheterization. The existing patent ductus arteriosus was combined with marked pulmonary arteriosclerosis and hypertension in the pulmonary tree which presumably exceeded peripheral arterial pressure. Hence, the direction of shunt was predominantly from the pulmonary artery into the aorta. Erroneous clinical impression of atrial septal defect was created by the very low oxygen value obtained from the superior vena cava. Since there was no sample from the inferior vena cava it must be assumed that higher oxygenation existed in this vessel in order to produce the elevated oxygen values obtained from mixed blood of the right auricle. Peculiar finding of increased cyanosis of the upper part of the body could be explained by higher oxygen demand of the upper part of the body of a patient lying in bed, the lower extremities being quite motionless in comparison with the upper part of the body.

monary conus prominent. Lung fields showed some increase of vascular markings.

Physiologic Data: Estimated blood flow: Systemic 4.72 liters/minute. Pulmonic 6.20 liters/minute. Estimated blood shunt: Flow through ductus, aorta to pulmonary artery 1.5 liters/minute.

Comment on Physiologic Data: Catheterization studies confirmed the clinical impression of patent ductus arteriosus, as suggested by a typical machinery murmur and wide pulse pressure. The ductus was calculated to shunt 24 per cent of the arterial blood into the pulmonary artery. The increased load of the arterio-venous shunt placed upon the ventricle added to circulatory demands of the latter part of pregnancy made immediate operative closure of the ductus advisable.

Operative Findings: At operation patent ductus measuring 1 cm. in length and .6 cm. in diameter was doubly ligated with silk. The previously existing thrill and murmur disappeared at once.

Newer Concepts in Rheumatoid Arthritis*

K. K. SHERWOOD, M.D.** AND BRUCE ZIMMERMAN, M.D.***

SEATTLE, WASH.

RECENT advances in arthritis are due to the acceptance of the hypothesis of metabolic etiology. From the classic description of gout, published by Sydenham in 1683, until the last few years, progress in the field of arthritis has consisted of fragmentation of "rheumatism" into a confusing multiplicity of vaguely defined syndromes. Sydenham differentiated gout in 1683; Bouillaud identified acute rheumatic fever in 1836; redundant nomenclature began when Garrod used the name rheumatoid arthritis in 1857 and Virchow countered in 1859 with arthritis deformans. Osteoarthritis and rheumatoid arthritis were differentiated pathologically by the English shortly before the turn of the century, though the first comprehensive paper on the subject was written by Nichols and Richardson of Boston in 1909. Since then, new arthritic names have rapidly multiplied. At present, the only two recognized chronic types of articular tissue reaction are called rheumatoid (atrophic or proliferative) and osteo-(hypertrophic or degenerative) arthritis. Apart from gout and certain rare metabolic arthropathies, all clinical types of chronic articular rheumatism correspond pathologically to one or the other of these two forms of tissue reaction. There is currently no agreement as to the tissue reaction in muscular rheumatism.

Degenerative joint disease (arthrosis, osteoarthritis, arthritis deformans of the German literature, senescent arthritis) is the most common type. This may be defined as a symptom complex produced by trauma or by use in excess of functional capacity. It usually occurs in joints with evidence of aging or trauma. The normal aging changes in articular cartilage are caused by dehydration and physiologic attrition. Fissuring, fragmentation and thinning of the cartilage result. Such changes decrease functional joint capacity and may cause instability. Edema of the periarticular soft tissue with or without hemorrhage is the pathologic criterion of symptom-producing osteoarthritis. Overuse of a joint with decreased capacity, or ligamentous strain secondary to instability, are the immediate causes of symptoms.

Any complicating condition that increases the work of the joint or favors the formation of edema may initiate symptoms or aggravate previously existing symptoms. Osteophytes (marginal joint calcification) occur as a response to strain, ven-

ostasis or both. Osteophyte formation, decrease of and irregularity of joint space are secondary to aging changes in articular cartilages. Hence, these osteophytes or spurs are roentgen evidence of use and age, not of clinical osteoarthritis.

Effective treatment of this syndrome is aimed at decreasing the functional demands placed upon the joint, at increasing its stability, and at reducing edema. Such treatment is mechanical and, when combined with treatment of existing complications (obesity, cardiac decompensation, varicose veins, faulty posture, etc.), is amazingly effective.

The second pathologic type of arthritis is rheumatoid arthritis (infectious, ankylosing, atrophic, proliferative). It constitutes 10 to 20 per cent of all cases of "rheumatism." This is characterized by periarticular vascularity, focal cellular accumulations, connective tissue proliferation and fibrinoid extracellular exudate. These changes are similar to those present in any nonpurulent granuloma. Recent detailed investigations have demonstrated that these structural changes in rheumatoid arthritis are not limited to the periarticular structures but are also present in the muscles, the nerve trunks, subcutaneous tissues and the heart.¹ It is now considered probable that in rheumatoid arthritis similar but smaller granulomatous changes occur perivascularly throughout the body. These pathologic changes are seldom clinically important except in the joints, muscles and subcutaneous tissues (subcutaneous nodules).

The third pathologic type of rheumatism is fibrositis or muscular rheumatism. This type of arthritis or rheumatism is characterized by the absence of any single constantly occurring anatomic change. Numerous anatomic facts, such as focal cellular aggregates, edema and fat herniations, have been ascribed as causing the clinical symptoms. Unfortunately, shortly after the publication of such observations, some skeptic usually demonstrates similar changes to be of frequent occurrence in "normal" individuals. This absence of accepted pathology is reflected in clinical confusion as to what is meant by fibrositis. Thus, fibrositis may mean to some an acute or chronic sprain (bursitis, tenosynovitis) and to others neurosthenia or hysteria (psychogenic rheumatism).

In defining rheumatoid arthritis, clarity will be gained if we outline the historic basis of the present etiologic hypothesis. Our fathers, and to a regret-

*Read at Sixty-first annual meeting of Washington State Medical Association, Spokane, Wash., Sept. 12, 1950.

**Clinical Assistant Professor, University of Washington School of Medicine.

***Clinical Assistant Professor, University of Washington School of Medicine.

1. Baggenstoss, A. H. and Rosenberg, E. F.: Visceral Lesions Associated with Chronic Infectious (Rheumatoid) Arthritis. *Arch. Path.*, 35:503-516, April, 1943.

table extent, our teachers, accepted the doctrine of the early bacteriologists that every disease was caused by germs and every disease had its specific germ. Consequent to this philosophy, arthritic research up to the close of World War II was almost exclusively devoted to either the anatomic or the bacterial aspect of rheumatoid arthritis. From 1890 until the close of World War I, scarcely a year went by without some enthusiast announcing the discovery of the germ that caused rheumatoid arthritis.

Due to bacterial studies, from 1912 through the subsequent two decades, the easily available teeth and tonsils and their accompanying ubiquitous streptococci were heralded as the cause of rheumatoid arthritis. As teeth and tonsils became more rare, skeptics pointed out that anything that made the patient sick enough, as for example, wholesale dental extraction, would temporarily improve his rheumatoid arthritis. This observation provided a rationale for fever therapy. Fever therapy for arthritis began about 1918-20 with the use of intravenous typhoid on alternate days in quantities sufficient to give a temperature of 105°. Even artificially introduced malaria was used. Such heroic treatment culminated in the various hyperthermic treatments of the 1930's.

Fortunately, certain skeptics prevented absolute acceptance of either focal infection as the cause or fever as the satisfactory treatment of rheumatoid arthritis. These skeptics repeatedly pointed out that arthritics have a frequency of focal infection no greater than that of the population as a whole.² Further, it was early established that fever therapy, regardless of either its severity or the means employed to produce it, was of purely temporary value. Again the bacteriologists helped out. Typhoid fever could be prevented by giving dead bacteria subcutaneously. Therefore, giving dead streptococci should not only prevent but cure rheumatoid arthritis. Most rheumatologists of the 1920-30's developed a favorite "arthritic" vaccine. We were guilty.

Skeptics proved that giving dead streptococci was statistically ineffective therapy. They repeatedly demonstrated that any medicine given with enthusiasm for a sufficient time results in two-thirds of the rheumatoid arthritics claiming to be "markedly improved." We gave physiologic saline to one hundred such arthritics and in a year's time over 60 per cent were markedly improved. That was twelve years ago and we are still occasionally embarrassed by one of these patients returning to us and insisting on receiving the same saline "shots" as in 1938.

In 1929 Forestier postulated that tuberculosis

caused rheumatoid arthritis, and as a cure introduced gold therapy. To date, it is the one agent that, over a long follow-up period, results in more maintained remissions than occur in control or aspirin treated cases. The mechanism of its beneficial action is unknown. It is effective only in peripheral rheumatoid arthritis and is inert when given to spondylitis (rheumatoid arthritis of the spine). In 1945, Pemberton noticed the similarity of appearance between some rheumatoid arthritics and cases of anorexia nervosa and was led to hypothesize that pituitary dysfunction might be a factor in rheumatoid arthritis. In the 1930's, Hench noticed that pregnancy³ and severe jaundice⁴ would cause an extremely rapid and complete remission in rheumatoid arthritis. In 1938, in a summary of the current views on rheumatoid arthritis, Hench⁵ concluded that, while infection was still a possible cause of the syndrome, it was unproven.

The more likely hypothesis was that rheumatoid arthritis consisted of an abnormal reaction to a nonspecific stress or injury. Hench's investigations of the remissions induced by pregnancy and jaundice were culminated in 1949⁶, when he and his associates announced that comparable remissions could be consistently produced by the administration in apparently unphysiologic quantities of the sugar regulating hormone of the suprarenal cortex. Further studies have proven that such remissions may be secured by giving cortisone directly or indirectly by the administration of the adrenocorticotrophic hormone of the anterior pituitary ACTH.

All investigations indicate these remissions are comparable to the remissions occurring in pregnancy. Neither hormone in any way influences the ultimate course of rheumatoid arthritis.⁷ Thus, we now can produce the temporary disappearance of the symptoms of rheumatoid arthritis with none of the disadvantages of pregnancy. Such a remission, like that occurring in pregnancy, is purely temporary. If long administered, cortisone results in adrenal atrophy, and ACTH in more widespread and less easily reversible complications. The most important results of Hench's discovery are, first, the general acceptance of the metabolic etiology of rheumatoid arthritis and, second, a tremendous stimulation to arthritic research.

3. Hench, P. S.: Ameliorating Effect of Pregnancy on Chronic Atrophic Arthritis, Fibrositis and Intermittent Hydrarthrosis. Proc. Staff Meeting, Mayo Clinic, 13:161-167, March 16, 1938.

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5. Hench, P. S.: Is Rheumatoid Arthritis Disease of Microbic Origin? R. H. Gordon and others; A Survey of Chronic Rheumatic Diseases. P. 35, Oxford Univ. Press, New York, 1938.

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This concept, rheumatoid arthritis as an expression of abnormal metabolism, has resulted not only in the appreciation of the true similarity of many described variants of rheumatoid arthritis, but has also reemphasized the essential likeness of all collagen diseases (lupus erythematosus disseminatus, periarteritis nodosa, scleroderma, dermatomyositis, and rheumatic fever). As with any metabolic disease, rheumatoid arthritis can only occur in individuals constitutionally possessing the specific metabolic anomaly. In these individuals symptoms will appear when they are subjected to sufficient stress, either environmental, emotional or physical. As in diabetes, the more complete the metabolic anomaly, the less will be the stress that is required to produce its clinical appearance. The acceptance of the hypothesis of a constitutional metabolic anomaly explains why some individuals develop rheumatoid arthritis and others, exposed to apparently identical or more severe insults, do not develop the disease.

Further, if rheumatoid arthritis is a constitutional metabolic anomaly, it is important to know the disease with which it is apparently incompatible. The ability of pregnancy and severe jaundice to produce a remission of the disease has already been stated. We have had two cancer cases, in which a remission of severe rheumatoid arthritis occurred with the onset of the nonicteric abdominal carcinomatosis. We have had many patients with both rheumatoid arthritis and asthma but we have yet to see their rheumatoid arthritis actively spread while their asthma was acutely incapacitating. We have never seen coexistent clinical cirrhosis of the liver and active rheumatoid arthritis. We have discovered after diligent search three out of approximately three thousand rheumatoid arthritics who were definitely alcoholics. We have never had a successful suicide in a patient known to have rheumatoid arthritis.

In a survey of eleven thousand psychotics and twenty-six hundred feeble minded, we found a complete absence of rheumatoid arthritis in cases with syphilis, manic depressive psychosis, melancholia, senile arteriosclerotic dementia and all forms of schizophrenia not associated with paranoid delusions. We have never seen active spreading rheumatoid arthritis and hemiplegia coexist in the same patient. We have never seen gangrene of the extremity in active rheumatoid arthritis, although Raynaud's disease is extremely common. Peptic ulcer and classical glomerulonephritis are exceedingly rare complications. In contrast, infections of the urinary tract, diabetes mellitus, tuberculosis, tumors and amyloid changes are of at least normal frequency. We believe a study of these above mentioned apparent incompatibilities may be of definite value in isolating the specific metabolic anomaly

whose clinical appearance we now designate rheumatoid arthritis.

This unknown but specific abnormal metabolism clinically known as rheumatoid arthritis becomes of significance when the individual possessing it is exposed to a sufficiently severe stress. There are three main types of stress which, acting either alone or in combination, may cause the latent abnormality to become clinically apparent. The stress which acting alone is least effective in producing symptoms of rheumatoid arthritis is the individual's inanimate environment. Studies have shown that rheumatoid arthritis has its greatest incidence in the middle and lower income groups⁸ residing in a temperate climate.⁹ All are aware that the patient with rheumatism is more comfortable in a dry, hot climate. Once the disease has developed, such a climate does not influence the course of rheumatoid arthritis. Likewise, all have had patients whose quiescent arthritis became reactivated upon moving to a damp, cold, shady house.

The second and more powerful type of stress which acts to bring this latent anomaly into clinical significance is emotional frustration. The rheumatoid arthritic is an irrational optimist; he may have had slowly progressive disease for twenty years but daily looks for and expects to find the magic cure that will dissipate his disease. With this irrational optimism, there is combined a profound emotional unhappiness. Last month one of our patients made this revealing statement: "Before this arthritis started, for eighteen months I was tense, nervous, restless at night and unable to relax." In a recent survey of one hundred consecutive rheumatoid arthritics which we had followed over one year, the single clinical and laboratory observation common to all the therapeutic failures was their lack of a satisfactory solution to a major emotional problem. In keeping with the importance of this emotional frustration to the development of their clinical metabolic decompensation are the subjects concerned in the frustration.

The emotional dilemmas of the arthritic do not concern themselves with superficial frustrations as, for example, financial hardship; they are commonly inadequacies of the family relationships with or without these inadequacies spreading into their entire social life. Our observed increased incidence of rheumatoid arthritis in the postadolescent and postclimateric periods may be partially explained because these are the two periods of life corresponding to great emotional reorientation. As would be expected in persons with such emotional frustrations, the rheumatoid arthritic is an asocial hypersensitive

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9. Pugh, L. G. C. E.: *Textbook of Rheum. Dis.*, p. 85. Williams and Wilkins, Baltimore, 1948.

perfectionist. The recognition of the importance of this emotional stress in the physiology of the arthritic patient with the resulting investigation into its clinical basis constitutes a major advancement in rheumatology.

The third type of stress, which alone or in conjunction with the other two types leads to the onset of rheumatoid arthritis, is physical stress. The occurrence of acute, severe or chronic minor intercurrent disease may be a sufficient physiologic overload to make apparent the previously hidden constitutional anomaly. We all look for and consequently frequently find rheumatoid arthritis beginning after an upper respiratory infection, pneumonia or pyelonephritis. Search with equal diligence reveals with surprising frequency that rheumatoid arthritis first became apparent after a major surgical procedure. Trauma, closely connected in both time and location with the development of rheumatoid arthritis, is less frequent. This is in contrast to the close association of trauma to the onset of symptoms of osteoarthritis, fibrositis or "compensationitis." It is our impression that this is due in part to the fact that the potential rheumatoid arthritic is, with few exceptions, definitely not a member of the accident-prone section of society.

Believing as we do that rheumatoid arthritis is a metabolic anomaly made clinically evident through the action of environmental, emotional and physical stresses, therapeutic emphasis is entirely different from treatment directed at curing an infection or eliminating a particular brand of streptococcus. What is best for the patient as an individual is the best treatment for his rheumatoid arthritis. We endeavor to secure the best possible surroundings and schedules for each patient. This means rest, work, play, food and housing should be such as to fit and not exceed his individual capabilities. These specific conditions must be itemized for each patient. He should be told how and what kind of rest, work, play, food and housing he should seek, emphasizing that these particulars are part of the cure. Constructive recreational activity cures more arthritics than nonutilitarian exercises. Avocational handicrafts, including bench work, should be part of the prescription given to every rheumatoid arthritic.

The second part of rheumatoid arthritic treatment is devoted to making the patient happier. Taking time to listen to his emotional troubles and getting him to discuss their possible solutions may make the difference between improvement and progression of the disease. One may point out the advantages and disadvantages of various proposed solutions to his social problems. One must always remember that only the patient can solve his particular problem with emotional success. He must choose his own solution to his particular dilemma,

neither being pushed nor carried into it by his doctor. The more one cultivates the technics of listening, suggesting and reassuring, the fewer will be one's failures. Such discussions are time-consuming but the satisfactory results obtained testify to their worth-while character.

The third section of rheumatoid arthritic treatment is medical. There is no cure for rheumatoid arthritis. Over a period of five to ten years, sixty to ninety per cent become nonprogressive.^{10,11,12} It should be specifically stated that neither cortisone, ACTH nor any known substitute for these two hormones effects a cure of rheumatoid arthritis. Aspirin deadens pain at the nerve level, cortisone stops reaction at the cellular level, neither cures. The most frequently neglected part of the physical treatment of the rheumatoid arthritic is complete diagnosis. Without evidence of systemic involvement, rheumatoid arthritis cannot be diagnosed. Likewise, when rheumatoid arthritis exists, complications are frequently present. Malnutrition, obesity, faulty shoes, chronic infections, dysfunction of the gastrointestinal tract or of the endocrine glands are the more common types of significant complications. These conditions should be actively treated. Their elimination removes a work load from the patient's physiology and thereby improves his likelihood of spontaneous recovery. Infected teeth should only be removed when the patient's general health will thereby be improved.

Pain relief should play an important part in the symptomatic treatment of rheumatoid arthritis. Aspirin properly buffered with nonsodium alkali should be used until the arthritis is either inactive or asymptomatic. Less than one per cent of arthritics are unable to take a properly buffered aspirin. Practically, we find no need to use either enteric coated tablets or intravenous salicylates. Small doses of phenobarbital or other sedatives usually enhance the effectiveness of such aspirin. We wish to endorse, emphasize and categorically affirm Hench's statement that any rheumatoid arthritic requiring narcotics for pain has another disease in addition to his rheumatoid arthritis. Heat relieves the pain and stiffness of arthritis and we encourage our patients to use hot water bottles, electric pads, infrared lights and similar heat sources. The electric blanket is an outstanding advance in the treatment of rheumatoid arthritis. Halfshell casts for bed rest periods and occasionally braces during ambulation give definite pain relief and substantially help to prevent disabling deformities.

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For temporary relief lasting hours or days, we have several types of therapy available. The dramatic remissions secured through the use of cortisone and ACTH are well known. We wish only to emphasize that they are not devoid of danger and, following their withdrawal, an exacerbation of the arthritis and severe mental depression may be expected. Usually less complete but nevertheless satisfactory remissions may be secured by less expensive and less dangerous drugs. Pemberton's observations of the relief obtained by starvation has been neglected in the last few years. We use this in the form of four ounces of unsweetened, unsalted fruit juice every four hours for twenty-four to thirty-six hours with a very satisfactory increase in comfort and functional ability. If edema is a factor in the patient's disability, the use of a rice diet for four to ten days will dramatically reduce it as well as greatly increase the patient's functional capacity. After five to ten days of this diet, improvement ceases and we have found no benefit in its longer continuance.

One may secure temporary relief by having the patient produce an excess of his own cortisone. This is accomplished by the use of foreign protein or similar fever therapy. If one wishes a rapid, major improvement, one gives sufficient foreign protein to produce a temperature of approximately 103°. Repeating such treatment from three to six times at slightly less than weekly intervals, gives in most cases a dramatic though temporary improvement (a preexisting high temperature or marked leucocytosis exists in most cases which fail to respond to such treatment). If one wishes longer continued adrenal stimulation, smaller doses of foreign protein may be employed. When doses are used which produce but slight temperature, there frequently occurs a gradual improvement which can be maintained for a period of months by weekly administration. Judging by preliminary experiments,¹³ foreign protein administration markedly increases cortisone excretion for a period of hours. It is therefore reasonable to hypothesize that if any benefit is obtained by the use of either foreign protein or the weaker arthritic type of vaccine, it is secured by means of the stimulation of the adrenal cortex.

Symptomatic medication should not be limited to treatment of complications and the use of heat, half-shell casts, analgesics and direct or indirect adrenal cortical hormone therapy. In energizing individuals with rheumatoid arthritis, we have found the use of benzedrine very helpful. Not only are corrective exercises better performed after this drug but more physical and mental activity is accomplished. There is, also, a limited but definite field for tonic preparations. Coexistent with the metabolic anomaly of

rheumatoid arthritis, there occurs a slower than normal diffusion of glucose from the blood stream into the intracellular spaces. The resulting plateau-type of sugar tolerance known to have occurred in rheumatoid arthritis with the erroneous assumption of poor carbohydrate metabolism furnishes the hypothetical basis for the administration of Vitamin B preparations. These may be given orally as a combination of the synthetic vitamins fortified by liver extract or, in certain circumstances, in the form of intramuscular liver.

Much has been written recently of the metabolic effects of theelin and testosterone.^{14,15} Theelin aids the retention of skeletal calcium, and retention of nitrogen is favored by the administration of testosterone. In occasional cases, these tonic effects may be of sufficient temporary help to warrant their use. For the commonly present anemia of rheumatoid arthritis, if the hemoglobin level is below 9 gms., transfusions are indicated. Irrespective of the degree of anemia, they are in rheumatoid arthritis of definite tonic value. Ferrous iron should be administered in cases with anemia, though usually its administration is not accompanied by dramatic benefits. The antihistamines are of definite value in preventing muscle cramps. Occasionally, they are apparently effective out of proportion to their alleviation of muscle cramps and of their sedative effect.

In addition to this symptomatic medication, we possess two apparently slightly curative drugs. We have alluded to the use of gold earlier in this discussion. Its good effects are limited to about 75 per cent of the cases of true peripheral rheumatoid arthritis and, when the disease recurs following a remission with gold therapy, gold may or may not be effective the second time. The mechanism of its action is entirely unknown. If each dose of gold is preceded by asking about the three P's, namely, purpura, pruritus, and polyuria and if monthly blood and urine analyses are performed, small dosage, in our experience, is seldom accompanied by serious toxicity. Toxicity, when encountered, can be neutralized by administration of BAL.

In the middle and late 1930's, Vitamin C had a short-lived vogue in the therapy of rheumatoid arthritis. It is undisputed that blood values of this vitamin are low in rheumatoid arthritis as well as in any debilitating or infectious disease. Recent work in rheumatic fever is suggestive that long continued administration of unphysiologic amounts of this chemical are "antirheumatic."¹⁶ This effect is usually manifested after three to five weeks of

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the administration of 0.5 gm. orally twice daily. In our hands, results are not dramatic but we believe it is worth the approximately \$10 which a three-month trial costs.

No attempt will be made in this paper to review either the older or the newer nonproven "cures" for rheumatoid arthritis. It should be pointed out that to date the only constant laboratory finding in all spontaneous or induced remissions of rheumatoid arthritis is the change in the sedimentation rate, essentially due to the blood fibrinogen level. There is suggestive work that increased urinary excretion of the amino acid histidine occurs in normal pregnancies and in all remissions of rheumatoid arthritis.¹⁷ A recent investigation revealed a similar increase of histidine excretion occurring in an artificially induced, rapid protein catabolism.¹⁸ Hence, this observation requires further study. Certainly the remissions induced by cortisone are not caused by changes in albumin, globulin, cholesterol, sodium, potassium, chloride, immune bodies or cells of the myeloid or lymphocytic series. Followup studies

and investigations by arthritic clinics throughout the United States have not substantiated the earlier claims of either desoxycorticosterone and intramuscular Vitamin C or pregnenolone. Adenyl triphosphoric acid so enthusiastically reported from Sweden¹⁹ has no converts in the major clinics of the United States. Vitamin D, calcium, sulphur, bee venom, theelin and crude liver are either inert or their observed effects in rheumatoid arthritis can be explained by their known nonspecific physiologic action.

There are few diseases of a chronic destructive nature in which two-thirds of the patients can consistently be "greatly improved" over a period of months by the application of sympathy and enthusiasm. With the removal of the urge to treat rheumatoid arthritis as a bacterial disease, there has resulted an exceedingly profitable reorientation. This new viewpoint emphasizes the importance of the total reaction of the patient to external environment, to emotional stresses and to physical disabilities. It has centered interest not on the pathology of rheumatoid arthritis but on its anomalous physiology and especially on changes in cellular chemistry. We may confidently look forward to the early elucidation of the exact metabolic anomaly which we now vaguely label rheumatoid arthritis.

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The Rh Factor in Obstetrics*

MARTIN S. SICHEL, M.D.

PORTLAND, ORE.

THE Rh factor was first shown to be present in human blood cells in 1940 by Landsteiner and Wiener.¹ During the last ten years an abundance of literature has appeared on this subject and considerable progress has been made in treatment of erythroblastosis fetalis. It is now generally accepted that the Rh factor is present in 86 per cent of the white race and lacking in the remaining 14 per cent. Individuals with the Rh factor are designated as Rh positive and those without as Rh negative. The Rh factor is positive in 85 per cent of colored Americans² and in 98-99 per cent of the

Mongolian race.³ It is inherited as a dominant Mendelian characteristic.

An Rh negative woman married to an Rh positive man may have a baby that is either Rh positive or Rh negative. Fetal blood sometimes gains access to the maternal circulation through the placental barrier. If the blood of an Rh positive baby in the uterus of an Rh negative mother gains access to the blood of the mother, an immune reaction⁴ is set up in the mother's blood against Rh positive erythrocytes. This immune reaction does not affect the first child unless the mother has been previously sensitized against Rh positive erythrocytes by transfusion with Rh positive blood prior to her first pregnancy. Hellman and Vosburg,⁵ in analyzing 27 cases of erythroblastosis,

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2. Santos, P. M. and Stepto, R. C.: Rh Factor in American Negro. *Am. J. Obst. & Gynec.*, 58:579, Sept., 1949.

3. Potter, E. L.: Rh—Its Relation to Congenital Hemolytic Disease and to Intragroup Transfusion Reactions. Chicago, 1946, The Year Book Publishers, Inc., pp. 90, 91.

4. Holman, A.: Personal Communication.

5. Hellman, L. M. and Vosburg, G. R.: Role of Transfusion in Etiology of Erythroblastosis. *J. A. M. A.*, 136: 79-81, Jan. 10, 1948.

found that in nine patients the disease followed previous blood transfusions.

In subsequent pregnancies in the presence of an Rh positive fetus, the immune reaction of the mother's blood is stimulated and agglutinins for Rh positive blood are formed. These agglutinins can then pass into the blood stream of the fetus and destroy an excessive number of fetal red blood cells and cause the disease known as erythroblastosis fetalis. The hemolysis of the fetal red blood cells in Rh positive babies is caused by a reaction between the agglutinin in the plasma and the factor in the red blood cells. It is estimated that this occurs about once in thirty pregnancies in Rh negative mothers.

Once a woman has been delivered of a baby with erythroblastosis, all subsequent Rh positive offspring will show the same disease. However, if an Rh negative baby is born, it will be normal.

The three clinical types⁶ of erythroblastosis are hydrops fetalis, icterus gravis and hemolytic anemia of the newborn, there often being an overlapping of at least two of these groups. Examination of the blood will usually show a definite anemia with a marked increase of immature nucleated erythrocytes.

In order to treat the newborn infant before clinical and pathologic manifestations of erythroblastosis develop, it is necessary to know prenatally the degree of isoimmunization that is occurring, particularly in the last trimester. The following plan should be used routinely with all obstetric patients.

At the time of the initial visit blood is taken for Rh determination. If the woman's blood is Rh negative, her husband's blood should be subject to Rh determination. If this is the first pregnancy, no further concern need be given unless the mother has been previously sensitized by a blood transfusion, in which case Rh titres should be taken. In all subsequent pregnancies the Rh titre should be taken at monthly intervals, starting at the sixth month. It has been definitely shown by the extensive work of Lucia⁷ and his associates, in a study of 179 Rh negative women and by Primrose⁸ on 391 Rh negative patients, that a high antepartum titre of agglutinating and blocking antibodies will usually result in some degree of hemolytic disease of the newborn. The agglutinating antibody may be present as early as the fifth month of pregnancy

and, if present at this time, offers a poor prognosis for the fetus. Blocking antibodies usually do not appear sooner than ten weeks antepartum and with the antigens now in use may be present in dilutions ranging from 1:2 to 1:512,⁹ and in some instances to 1:1024 or higher.¹⁰ Pregnancy is allowed to proceed to term, no early inductions are performed and cesarian section is done only for definite obstetric indications, regardless of the Rh titre.

At delivery, sufficient cord blood is taken to perform the following examinations: complete blood count, Rh factor, nucleated red blood cell count and blood type. The cord is left approximately three inches long and tied. If the infant is Rh negative, no further concern need be given as a healthy, normal baby should be born, even if there is some rise in the mother's titre which could still be present from previous sensitization. Nevertheless, it is still advisable to check the baby by subsequent blood counts. If the infant is Rh positive, the above examinations normal and the baby's clinical condition satisfactory, the policy of expectancy can be adopted. Further examinations of the baby's red blood count, hemoglobin and nucleated red cells should be performed daily until danger is past.

Treatment should be given, if anemia is present at birth or if a subsequent drop in hemoglobin and red blood count occur. The presence of an excessive number of nucleated red blood cells is also indicative of treatment. Clinical signs indicating the need for treatment are jaundice, edema or enlargement of the spleen or liver.

The accepted method of treatment is exchange transfusion, given as soon after delivery as possible, if clinical and laboratory signs of erythroblastosis are present at birth or as soon as symptoms or signs of jaundice or anemia develop. In certain selected instances it is advisable to institute treatment immediately after birth of the infant. A baby, born of a woman who has already lost one or more infants from erythroblastosis and who has a high antepartum titre, should receive immediate treatment rather than waiting for clinical or laboratory signs to develop. Also, if a woman has a high antepartum titre, who has not previously lost a child, immediate treatment should be given her newborn infant. Rh negative blood from a female donor¹¹ should be used for transfusion.

Boyden¹² reports seven cases of erythroblastosis

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treated by exchange transfusion with recovery. Ginsberg and Feldman, in analyzing 50 cases of erythroblastosis, report 11 infants in whom exchange transfusion was used all of whom recovered and now they recommend this method as the treatment of choice. Wiener and Wexler¹³ report exchange transfusion in 74 infants with 12 deaths, a mortality rate of 16.2 per cent; however, in this series no mention was made as to whether female donors were used. Diamond and Allen report 42 infants with erythroblastosis treated by exchange transfusion, using female donors with no deaths.

There are three technics available to perform an exchange transfusion on the newborn infant. The one used will depend entirely on individual preferences and the length of time that has elapsed between birth of the infant and that selected for transfusion.

Replacement transfusion may be given either through the umbilical¹⁴ or saphenous veins. The umbilical should only be used for a period of approximately twelve hours following birth, as after this length of time the vein may be thrombosed, making transfusion difficult or impossible. Saphenous vein transfusion,¹⁵ given high in the groin, can be used, regardless of the length of time following birth of the infant. Whatever vein is selected, the plastic catheter of Diamond¹⁴ can be used to advantage. In the saphenous vein technic it is gradually passed through the saphenous, femoral and common iliac veins and finally into the inferior vena cava. Replacement of blood can then be performed in 20 cc. quantities until 500 cc. have been given over a period of from one to two hours. It is advisable to use heparin, 10 mg. to 150 cc. of saline solution to keep the apparatus clear; no heparin should be injected into the infant's circulation. Either group O or group specific Rh negative blood from a female donor should be used.

A third method is the open technic of the radial artery, saphenous vein combination.^{16,17} The site for transfusion is the saphenous vein anterior and superior to the medial malleolus; at the same time a V-shaped incision is made into the radial artery to permit the flow of blood from the infant's circulation; 500 cc. of blood can then be given in one to one and one-half hours, permitting an almost complete replacement of the infant's erythrocytes.

Regardless of the technic used, 1 cc. of 10 per cent calcium gluconate solution for each 100 cc. of transfused blood is given to neutralize the citrate solution used during transfusion. Penicillin in 10,000-unit dosage is administered every three hours for the ensuing three or four days.

The following case histories of Rh negative mothers, all delivered within the first four months of this year, illustrate the points on management already discussed. All of the babies are alive and normal.

Case Reports

Case 1. This patient was a gravida 2, age 25—first baby normal, husband Rh positive. Agglutinating antibodies, none. Blocking antibodies, none. She was delivered at term on February 3, 1950, of a healthy normal female infant. Blood studies on the infant were as follows:

Date	Hemoglobin	Red Blood Cells	Nucleated Red Cells*
February 3, 1950	131%	6,200,000	7
February 4, 1950	105%	5,000,000	0
February 5, 1950	116%	5,680,000	0

*Nucleated red blood cells per 100 white blood cells.

Case 2. This patient was a gravida 2, age 29. Her first baby was normal, husband Rh positive. Agglutinating antibodies, none. Blocking antibodies, none. She was delivered at term on February 8, 1950, of a clinically normal female infant. Blood studies on the infant were as follows:

Date	Hemoglobin	Red Blood Cells	Nucleated Red Cells
February 8, 1950	140%	6,970,000	3
February 9, 1950	140%	6,370,000	0
February 10, 1950	131%	5,700,000	0

Case 3. This patient was a gravida 2, age 23. Her first baby was normal, husband Rh positive. Agglutinating antibodies were present in a dilution of 1:8; there were no blocking antibodies. She was delivered of a healthy normal female infant on February 14, 1950. No subsequent jaundice developed. Blood studies on the infant were as follows:

Date	Hemoglobin	Red Blood Cells	Nucleated Red Cells
February 15, 1950	135%	6,510,000	1
February 16, 1950	140%	6,500,000	0
February 17, 1950	140%	6,900,000	0

Case 4. This patient was a gravida 2, age 25. Her first baby was normal, husband Rh positive. Agglutinating antibodies, none. Blocking antibodies, none. She was delivered at term on April 12, 1950, of a healthy normal male infant. Blood studies on the infant were as follows:

Date	Hemoglobin	Red Blood Cells	Nucleated Red Cells
April 12, 1950	140%	6,100,000	0
April 13, 1950	121%	5,120,000	0
April 14, 1950	100%	5,400,000	0

Case 5. This patient was a gravida 3, age 38. Her first baby delivered in 1939 was normal. Her second child, delivered on April 19, 1942, was clinically normal at birth, subsequently developing jaundice and later anemia and, despite repeated blood transfusions of 75-100 cc., died on June 4, 1942, of erythroblastosis fetalis. Blood studies on this infant were as follows:

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Date	Hemoglobin	Red Blood Cells	White Blood Cells
April 23, 1942	90%	3,140,000	6,000
April 30, 1942	95%	4,500,000	16,800
May 6, 1942	65%	3,000,000	11,850
May 20, 1942	58%	2,840,000	8,000
May 28, 1942	49%	1,880,000	6,650
June 2, 1942	69%	2,740,000	4,600

Subsequent Rh typing in 1946 revealed the mother to be Rh negative and the husband Rh positive.

A third pregnancy occurred, the last menstrual period being July 15, 1949, and the expected date of confinement April 22, 1950. On January 18, 1950, the Rh titre showed agglutinating antibodies present in a dilution of 1:2; there were no blocking antibodies. On March 21, 1950, blocking antibodies were present in a dilution of 1:128; there were no agglutinating antibodies present at this time. In view of the previous history of erythroblastosis in her second child and the antepartum rise of blocking antibodies in this pregnancy, some degree of hemolytic disease of the newborn was expected and preparations were made to have Rh negative woman's blood available for an exchange transfusion. Labor was induced on April 25, followed by a short labor and the delivery of a clinically normal male infant; no subsequent jaundice or enlargement of the spleen or liver occurred and transfusion was not necessary. (Pediatrician, Scott Good-night.)

Examination of the cord blood was as follows: Hemoglobin, 108 per cent; red blood count, 5,200,000; white blood count, 22,050; differential count normal; nucleated red blood cells, 10; Rh factor negative; blood type 2A; Coombs test negative.^{18 19}

Subsequent studies on the infant's blood was as follows:

Date	Hemoglobin	Red Blood Cells	Nucleated Red Cells
April 25, 1950	98%	4,700,000	0
April 26, 1950	91%	4,250,000	2
April 27, 1950	111%	5,200,000	0

If this third child had been Rh positive, it is very likely that some degree of erythroblastosis would have been present.

The Rh negative factor is not believed to be a causative factor in early abortion. Analysis of a

large series of spontaneous abortions was undertaken by Overstreet and associates²⁰ over a four-year period from 1944 to 1947 and they concluded that isoimmunization in the Rh negative woman is not a causative factor in spontaneous early abortion. In their series of 1,038 pregnancies occurring in 512 Rh negative mothers, there were 129 abortions or 12.4 per cent. A similar series in Rh positive women showed that in 1,129 pregnancies occurring in 534 Rh positive mothers that 171 abortions or 15.2 per cent took place.

SUMMARY

1. The Rh factor should be determined in every expectant mother.
2. If the prospective mother is Rh negative the husband's blood should also be examined.
3. An Rh negative mother and Rh positive father will have a nonerythroblastic first child unless the mother has been sensitized by a transfusion.
4. In all subsequent pregnancies the Rh negative mother should have titres made on her blood during the last three months of pregnancy. A high titre is indicative of the probability of some degree of hemolytic disease in the infant.
5. Examination of the cord blood should be made at the time of delivery for the presence of anemia. A clinically normal infant should have its blood examined during the first three days of life and treatment should be instituted if clinical signs of erythroblastosis or anemia develop.
6. Exchange transfusion with Rh negative woman's blood immediately after birth or as soon as signs of anemia appear is the best treatment for an infant with erythroblastosis.
7. Not all infants with hemolytic disease can be saved but careful attention to the above principles will save a large majority.

18. Coombs, R. R. and Mourant, A. E.: New Test for Detection of Weak and Incomplete Rh Agglutinins. *Brit. J. Exp. Path.*, 26:255-266, Aug., 1945.

19. Coombs, R. R.: In-Vivo Iso-sensitization of Red Cells in Babies with Hemolytic Disease. *Lancet*, 1:264-266, Feb. 23, 1946.

20. Overstreet, E. W., Traut, H. F., Hunt, M. and Lucia, S. P.: Does Rh-Isoimmunization Cause Early Abortion? *Am. J. Obst. & Gynec.*, 54:235-241, Aug., 1947.

Annual Trustees Meeting

The annual meeting of the trustees of Northwest Medical Publishing Association was held on January 21 in Seattle. Present were K. H. Martzloff, Portland; J. V. Straumfjord, Astoria; Gayton S. Bailey, Seattle; F. C. Harvey, Spokane; L. A. Hopkins, Tacoma, and D. M. Loehr, Moscow. R. W. Espersen, Klamath Falls; C. O. Armstrong, Moscow, and Alexander Barclay, Coeur d'Alene, were unable to attend.

Officers for Northwest Medical Publishing Association elected for the coming year are as follows: President, K. H. Martzloff; vice-president, L. A. Hopkins; secretary, H. L. Hartley, and business manager and treasurer, Mr. Kirby Torrance.

Officers elected for NORTHWEST MEDICINE are: Clarence A. Smith and Herbert L. Hartley, co-editors; Mrs. M. F. Barendregt, managing editor, and Mr. Kirby Torrance, business manager and treasurer.

A resolution was drawn up to be presented to Dr. Smith in which the trustees:

"... Do hereby thank Dr. Clarence A. Smith for his many years of devotion to NORTHWEST MEDICINE; do herein express our deep gratitude for his continuous editorship, his scholarly work and his high ideals which have won for him and the Journal such a unique position in American medicine; and sincerely hope that he can continue to give of his talents for many years to come."

The secretary was also given instructions to write a letter to Miss Constance Hulbert (who retired last year) expressing the appreciation of NORTHWEST MEDICINE and the Board of Trustees for her many years of long and faithful service.

The trustees voiced their approval and thanks for Mr. Torrance's successful management of NORTHWEST MEDICINE for the year 1950 and expressed their confidence in his continued managerial activities for the year to come.

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RESEARCH IN THE SERVICE OF MEDICINE



STATE SECTIONS

**OREGON STATE
MEDICAL SOCIETY**



**ANNUAL MEETING
PORTLAND, OCT. 10-13, 1951**

President, W. J. Weese, M.D., Ontario

Secretary, R. F. Miller, M.D., Portland

Executive Secretary, Mr. C. C. Faley, Portland

Opinions, Views or Comments presented in articles appearing in this section are those of the individual authors and are not necessarily those of Oregon State Medical Society.

Medical Notes

Midyear Meeting of House of Delegates

At its February meeting, the Council of the Oregon State Medical Society designated April 28, 1951, as the date for the 1951 midyear meeting of the House of Delegates and chose Portland as the place of the meeting.

As in former years, the date selected immediately follows the annual meeting of the Alumni Association of the University of Oregon Medical School, and the annual Sommer Memorial lectures. Location of the meeting has not been definitely selected but most likely will be in the Tyrolean Room of Portland's Benson Hotel. Prospective delegates should make their own reservations in Portland. It is anticipated the meetings of the delegates will be concluded in the one day.

National Blue Shield Service, Inc., Elects Directors

The insurance company which the A. M. A. house of delegates formally said it didn't want, but which it "guessed" it probably would get when it "divorced" the old Associated Medical Care Plan, but told them to use their best judgment, has elected its initial board of directors, according to a recent enrollment letter from Blue Shield Medical Care Plans.

Plans subscribing to the capital funds represented a little over 80 per cent of the entire Blue Shield membership, and numbered 43 at last report. Leading plan subscribers were Michigan, with \$60,000, United Medical of New York and California Physicians' Service, with \$50,000 each; Ohio Indemnity with \$40,000; Pennsylvania, with \$25,000; Colorado, with \$15,000, and Indiana, Minnesota, Kansas, Missouri and Dallas, with from \$12,500 to \$10,000 each. Several plans contributed nominal sums of \$100 to \$500 each, while a number of plans, including New Jersey, Utah and Oregon, did not contribute. Total capital funds raised at last report was \$378,019.00 and the concern was incorporated and chartered in Ohio on December 5, 1950.

The board is composed of the trustee representatives to the commission from the eleven districts and Paul R. Hawley, M.D.; Jay C. Ketchum, Charles H. Coghlan and W. M. Bowman, for the required fifteen members. The eleven trustee members are L. K. Sycamore, M.D.; Frederic E. Elliott, M.D.; Carlton E. Wertz, M.D.; J. A. Daugherty, M.D.; A. R. Lutz, M.D.; O. B. Owens, M.D.; L. Howard Schriver, M.D.; R. L. Novy, M.D.; F. L. Feierabend, M.D.; A. J. Offerman, M.D., and Donald Cass, M.D.

A full report of the present and proposed activities of this "national enrollment agency" will likely be given at the annual meeting of the Blue Shield plans in April.

Isotopic Iodine Tracer Lab Inaugurated in Portland

A clinic has been established at Good Samaritan Hospital, Portland, Oregon, for the use of radioactive iodine in the diagnosis and treatment of thyroid diseases, in which this method applies. Patients may be referred to this clinic by any properly licensed physician, and no patient will be accepted by the clinic unless he has been referred by such a physician.

The diagnosis of thyroid function as applies to the gland's ability to concentrate iodine will be made on any properly referred patient, but only selected patients will receive therapeutic doses, it being understood that this method of therapy has its limitations.

The result of the tracer dose uptake determination and the recommendation of the clinic will be sent to the referring doctor after which arrangements can be made for treatment with radioactive iodine if such is indicated and if so desired. The cost of the tracer-dose uptake study will be \$15.00 and a course of therapy will be \$150, regardless of the number of doses of I-131 required to produce a therapeutical effect. The cost of establishing this program can only be estimated at this time, and changes in the quoted charges may be necessary.

While any person may have an estimation of thyroid activity as elicited by the tracer-dose uptake determination, the clinic has attempted to limit the selection of cases for therapy. In general, the following criteria will hold:

1. All patients treated should be 40 years of age or older, unless there is demanding indication in patients of lesser age.

2. Hyperthyroidism of Graves' Disease in older age group.

3. Hyperthyroidism of Graves' Disease recurrent after definitive medical or surgical treatment.

4. Patients with carcinoma of thyroid in whom the primary site of pathology has been eradicated by surgery and in whom tracer uptake studies show convincing evidence that such metastases as may be present are avid for iodine.

For further information or for appointment please communicate with Radioisotope Committee, Good Samaritan Hospital, 2266 N. W. Marshall Street, Portland 10, Oregon.

Pete the Pest Says

Pertinent Comment: Credit is being given Dr. F. Howard Kurtz, Salem member of state public policy committee, for best comment of day at recent legislative hearing on house bill 254, which would define word "physician" in relation to Oregon laws.

Hearing was held by house medicine committee to which bill had been referred. Attendants were chiefly exponents of chiropractic trade, with some naturopaths and few osteopaths; four medicos present (excluding Dr. Dammasch, committee chairman who leaned over backward to insure cultists a fair hearing) were sadly outnumbered. Chiro after chiro stated his views bill if passed into law would cramp chiro efforts, overlooking implication chiro style would not be cramped if cultists were not already going beyond provisions of their licensing law in their procedures.

What was supposed to be final chiropractic thrust was delivered by secretary board of chiro examiners who said in effect the questions asked by his board in last January examinations were identical with if not tougher than those asked by Board of Medical Examiners for medico candidates, then tossed bundle of questions impressively on committee table.

This was too much for the Salem medico, who leaned forward and cracked: "Who cares about the questions? Let's see the answers!"

Obituaries

Lester M. Lehrbach, 67, prominent Roseburg physician and surgeon, died at his home on January 26, 1951, after a lengthy illness. Dr. Lehrbach was born in Arcadia, Wisconsin, in 1884, attended local schools

and obtained his bachelor's degree from the University of Wisconsin in 1902. His medical work was taken at Northwestern University School of Medicine and after postgraduate training he came to Oregon to practice, first locating at Junction City in 1908. Four years later he moved to Roseburg, where he practiced continually until his final illness. Dr. Lehrbach was active in Roseburg civic affairs, a member and holder of many offices in the Douglas County Medical Society and Southern Oregon Medical Society. He was a member of the Oregon State Medical Society and the American Medical Association.

Ralph Ferrien Davis, 70, Portland ophthalmologist and rhinologist, died at his home on February 8, 1951, after a prolonged illness. Dr. Davis was a native of Boise, Idaho. He completed his preliminary education in Idaho institutions and for his medical work attended the University of Oregon Medical School, graduating in 1909. Following postgraduate work in the East and Europe, he came to Portland and established practice in his specialty where he remained active until illness forced his retirement a few years ago. At the time of his retirement he was clinical professor of otolaryngology at the University of Oregon Medical School. Dr. Davis was a member of the Multnomah County Medical Society, Oregon State Medical Society, American Medical Association and a number of scientific societies connected with his specialty.

Robert Harold Swinney, 46, prominent Portland surgeon, was drowned in the Lewis River in Southern Washington following a fishing accident on February 8, 1951. Dr. Swinney was born in Oklahoma in 1905 and attended the schools of that state. He received his medical degree from Washington University of St. Louis and took postgraduate work in surgery in New York hospitals. In 1941 he located for practice in Portland and was increasingly active in his specialty and in medical matters generally. Dr. Swinney was a member of the Multnomah County Medical Society and for the past several years was the chairman of its Oregon Physicians' Service supervisory committee. He was a member of the Oregon State Medical Society, the American Medical Association and a number of scientific organizations dealing with surgical affairs. In September, 1950, he was elected a trustee of Oregon Physicians' Service by the Council of the Oregon State Medical Society and was a member of the board of directors at the time of his death.



WASHINGTON STATE MEDICAL ASSOCIATION



ANNUAL MEETING SEATTLE, SEPT. 9-12, 1951

President, K. L. Partlow, M.D., Olympia

Secretary, J. W. Haviland, M.D., Seattle

Executive Secretary, Mr. R. W. Neill, Seattle

Report from the State Legislature

Most amazing measure proposed during the present session of the State Legislature, confining thinking to health bills, is the one sponsored by the Washington State Naturopathic Association. It requires four years of high school, two years of college and two years education in a naturopathic school. In addition, and this is the amazing part of the proposal, passage of the Basic Science examination is a prerequisite to licensure in Washington State. This is the main contention of the medical profession in its fight to maintain minimum standards for all healing arts.

The Naturopathic Association withheld introduction of its measure in deference to the chiropractors and sanipractors until so late in the session it is very doubtful the bill will receive serious consideration. It is precedent-making, however, as we can always point to this session as the time when one of the groups which has been fighting basic requirements admitted the necessity and offered to meet minimum standards by legislative action. This the chiropractors never have offered to do.

This is the year the chiropractors felt was favorable to their cause. A chiropractor had been elected to the legislature, an accomplishment which the medical profession failed to match. Their bill was introduced early in the session and thus gained the advantage of certain floor action. The bill came out of Rules Committee in the House and slid back into that committee for third reading and final passage, without controversy. The Rules Committee was not constituted so favorably for the chiropractors as was the Medicine and Dentistry Committee, and much advantage was gained by opponents of the bill during the time it lay swamped in controversy in that body. The controversy, strangely enough, existed among those opposed to the bill. Nine of the fifteen members took a negative view of the bill but they were divided as to how the coup de grace should be accomplished. About half of the negative members thought the full House should take the responsibility of deciding the fate of the measure, while the other half felt it should be killed in Rules Committee. By this time, trading of bills came into vogue and the chiropractor measure came out unexpectedly for a vote.

Three weeks earlier, legislative representatives of

the medical profession predicted the outcome, and offered the chiropractors the advantage of choosing the method by which their bill would be defeated—Rules Committee, or by vote on the floor. They chose the latter, in order to get the members of the House on record, even though it was embarrassing to a number of those favorable to their cause. The vote was 56 to 42, with one member absent who was pledged against the bill. The chiropractors packed up their bags and went home. However, careful scrutiny of all bills is being maintained to make sure the dead measure is not "tacked onto" some other bill introduced by number and title only.

Greatest amount of satisfaction gained in this victory is the way in which the Association members and the Auxiliary responded to pleas for help. It is encouraging to note that both the Auxiliary and individual members of the Association have become well-enough acquainted with the situation to be able to respond to requests for help without being prompted as to reasons for requesting legislators to vote against the measure.

There was a case or two of courtesy voting. There also was a case or two of lack of education of the legislators by the medical profession on the local level (sic). In the main, the result was quite satisfactory.

It is notable that 15 Democrats voted against the chiropractors, even though an attempt was made to make a party issue of the matter. These 15 Democrats turned the tide in our favor. One Democrat voted for the measure in spite of the fact he has two brothers in medical school and soon will marry a daughter of a very prominent physician. Two or three Democrats would have left the floor to escape being recorded in favor of the measure had there not been a "call of the house." This legislative maneuver requires all members to be present, except those specifically excused for good reason.

Chiropractor-lobbyists admitted they had encountered the best educational job among members of the House that they had experienced, thus giving the medical profession credit for doing a magnificent job of selling the necessity for meeting by all healing arts the requirements of the Basic Science law.

Medical Notes

STATE MEDICAL BUREAU MOVES. Washington State Medical Bureau has moved its offices from White-Henry-Stuart Building to 211 Douglas Building, Seattle, where increased space and facilities will allow

expansion. Personnel moving with the bureau includes John Steen, manager; "Jeff" Warren, assistant; Mrs. Diane Seth, Mrs. Dorothy Francis and Miss Pat Ellis.

SIXTEEN HUNDRED CLAIMS MONTHLY. The Washington State Medical Bureau is now handling 1600 claims a month, totaling approximately \$20,000, for out-patient service connected disabilities of veterans. These claims were formerly handled individually between each county and the Veterans Administration. The changeover was effected with minimum delay and inconvenience to both patients and doctors. Doctors are receiving their fees in three to six weeks after filing claims, according to John Steen, Bureau manager.

The Bureau is also starting to service Spanish-American War Veterans who, under the new act of Congress, are now entitled to benefits for any and all disabilities. There are about 2500 eligible men in the state, many of them living in soldiers' homes at Retsil and Orting.

ENDOCRINOLOGY ASSEMBLY. One of the leading post-graduate courses in the nation in diagnosis and treatment of glandular diseases will be held at the University of Washington School of Medicine in July. The announcement was made by Robert H. Williams, head of the Department of Medicine. This is the National Postgraduate Assembly in Endocrinology, including diabetes. The course is expected to attract at least 300 physicians from throughout North America. Lester J. Palmer, head of the diabetes clinic of the Mason Clinic and president of the American Diabetes Association, and Williams will make arrangements for the course. A week-long series of lectures and clinics will be given, beginning July 1.

HOLLISTER-STIER MOVES TO NEW QUARTERS. Hollister-Stier Laboratories, Inc., has moved into modern biological laboratories at S. 107 Division, Spokane, Wash. The \$100,000 laboratory was completed last month and its staff of 15 now produces allergenic extracts that are shipped throughout the world. The new laboratory marks expansion for Hollister-Stier and separation of its biological and clinical operations. Robert F. E. Stier, vice-president and medical director, will maintain clinical laboratories in the Paulsen Medical and Dental Building and continue his medical practice as an allergist.

HORMONES WOULD AID A-BOMB CASUALTIES. Cortisone and ACTH, the wonder-working hormone compounds, would be of great value in treating atomic-bomb casualties, Robert H. Williams, University of Washington School of Medicine, told a meeting of medical researchers recently. It was the opening session in Seattle of the annual meeting of Western Section, American Federation for Clinical Research, attended by researchers from Western states. Williams, who is directing one of the leading research programs in ACTH and cortisone, reported that the substances are proving of value in treating severe burns. He said they also minimize ill-effects from excessive radiation.

Society Meetings

CLARK COUNTY. The regular meeting of the Clark County Medical Society was held at the Royal Oaks Country Club on February 7. Following dinner and social hour, Dr. Kenneth Swan, Professor of Ophthalmology at the University of Oregon Medical School,

presented a paper on "New Developments of Fundusoscopic Evaluation of Vascular Disease."

THURSTON-MASON SOCIETY. Thurston-Mason Society held its first meeting of the year at the Olympic Country Club on January 23. Ralph Highmiller of Olympia and Homer Frank of Shelton were installed as president and secretary-treasurer, respectively, for 1951. Speakers for the evening included Robert A. Tidwell, who discussed the diagnosis and management of rheumatic fever, and William M. Kirby, who spoke on its pathogenesis and prophylaxis. Mr. Ralph Neill, executive secretary of Washington State Medical Association, reported his analysis of medical bills likely to be considered by the current session of the Legislature.

PACIFIC COUNTY. The annual meeting of the Pacific County Medical Society was held at the Sea-Sons Inn in Long Beach, January 26. Officers for 1951 were elected as follows: President, O. R. Nevitt, Raymond; vice-president, J. A. Christensen, Long Beach; secretary-treasurer, J. C. Proffitt, South Bend. J. E. Galbraith, Grays Harbor Department of Health, and M. P. Graham, head of the physicians and surgeons civilian defense for Grays Harbor, were present and spoke on the organization and functions of the Civilian Defense Program.

The annual meeting of the Pacific County Medical Service Corporation was held at the same time and place. The following officers were elected for 1951: President, C. W. Van Rooy, Long Beach; vice-president, L. C. Neace, Ilwaco; secretary-treasurer, O. R. Nevitt, Raymond.

BENTON-FRANKLIN COUNTY. H. M. Parker, manager of the Health Instrument division of the Hanford Works, was guest speaker at a dinner meeting of the Benton-Franklin County Medical Society in Pasco, January 24. Dr. Parker spoke on Radiation Protection in Industry and Civilian Defense.

GRAYS HARBOR COUNTY. Mr. John Niles, manager of Grays Harbor Medical Service Corporation, announces the 1951 officers of that organization as follows: President, W. H. Hardy, Aberdeen, and secretary, M. C. Lindel, Montesano. Meetings are held every third Wednesday.

SPOKANE COUNTY. The Spokane County Medical Society cancer detection center is among 609 clinics and 151 detection centers that have been approved by the American College of Surgeons, according to Paul R. Hawley, director of the college. The approvals are based on personal surveys by representatives of the colleges.

JOHN TOLAN HEADS MEDIC GROUP. John F. Tolan of the Mason Clinic, Seattle, has been installed as president of the Puget Sound Academy of Ophthalmology and Otolaryngology. Tolan took office at the annual banquet of the group January 13. Harold F. Thorlakson, Seattle, was named president-elect and Willard Goff, Seattle, secretary-treasurer.

Personal

Edward F. Cadman, a former resident of Wenatchee, has recently returned to his home town to set up practice. He is now associated with the Wenatchee Valley Clinic. Dr. Cadman obtained his B.S. degree

from the University of Washington and his M.D. from Columbia University. He took surgical internship at the Presbyterian hospital in New York City. Following his discharge from the Army, where he was chief of surgical service at March Field Station Hospital for two years, he served as resident surgeon at King County Hospital in Seattle. He is a junior member of the American College of Surgeons and a member of the Association of Military Surgeons.

From its local Easter Seal funds, the Pierce County Society for Crippled Children and Adults, in the interest of providing further services to cerebral palsied children, has awarded a scholarship for two weeks of special graduate work in new cerebral palsy trends to Charles E. Kemp, Tacoma pediatrician. The course will be presented at the Cook County Graduate School of Medicine, Chicago, starting July 9.

James H. Closson, a member of the Finch Memorial Community-College hospital staff since September, 1949, has been appointed acting director of student health service at Washington State College. Dr. Closson succeeds B. C. Houghton, who was named director of the student health center and associate professor of preventive medicine at the University of Washington.

Norbert E. Medved, who until recently was Lt. Medved, (j.g.), at Bremerton and Bainbridge Island naval posts, has located in Yakima and is now associated with Victor E. Johnson in the practice of medicine. Dr. Medved, a native of Idaho, received his M.D. from Creighton University, Omaha, and interned at Sacred Heart Hospital, Spokane.

H. C. Shephard, Enumclaw, has taken over the practice of Frederick L. Hahn of Auburn, who has been called to military service. Dr. Shephard, born and reared in the Puyallup Valley, is a member on the staffs of the Enumclaw, Auburn and Renton Hospitals and is also a member of the King County Medical Service Bureau.

Roger F. Hisey has purchased the Wendt home in Granger and has established a general practice office in a part of the building. It is the first time in several years that Granger has had a physician's office. Dr. Hisey has been on the staff of an Eastern Oregon hospital at Pendleton for the past two years.

Grover C. Carter from the Veterans' Administration Hospital at Salt Lake City, Utah, was added to the surgical staff of the Veterans' Hospital in Spokane when another floor was opened in January. Dr. Carter will aid the three surgeons previously assigned to the hospital.

With the recent completion of the medical offices and clinic of J. Gordon Adams and Leonard Asmundson, Enumclaw now has one of the most completely rounded-out medical treatment facilities for a city of its size in the nation. The new clinic includes numerous rooms for consultation, examination and treatment, a complete x-ray section, a modern laboratory, physio-therapy room and a very new and up-to-date surgery for emergency and minor operations.

New offices for A. V. Mills and F. C. Klopfenstein have recently been completed in Yakima. The combination offices in the new one-story building include reception rooms, business desks and service rooms.

Hospital News

NEW HOSPITAL CHIEF. The appointment of John F. Le Cocq, Seattle orthopedic surgeon, as chief of staff at Swedish Hospital, was announced recently by Mr. John A. Soderberg, president of the hospital board of directors. Le Cocq succeeds Ralph H. Loe who served two years in the post. Frank H. Wanamaker was appointed assistant chief of staff and Charles E. MacMahon secretary of the executive committee.

HUNT TAKES OVER HOSPITAL DUTIES. Mr. Max L. Hunt is the new administrator for the Yakima Valley Memorial Hospital, Yakima. Hunt previously managed the 60-bed St. Charles Hospital at Bend, Ore., and before that was assistant administrator for three years at the Good Samaritan Hospital in Portland, Oregon.

SPECIAL WARD FOR CHILDREN UNIQUE. Eastern State Hospital soon will be the only mental institution in three Northwest states to have a special ward for treatment and observation of children who are mentally ill. R. H. Southcombe, hospital director, said he believes the Medical Lake institution is the first mental hospital in Washington, Idaho or Montana to create juvenile wards. Juvenile wards, however, are fairly common in Eastern mental hospitals.

HOSPITAL FOR RAID CASUALTIES. The University of Washington plans to set up an emergency hospital as part of its civil defense program, Col. George F. Baier, head of the Medical Corps Department of the R.O.T.C. at the university, announced recently. The hospital, which will handle casualties in case of an air attack, will be set up in the Health Sciences Building. Edward Turner, head of the School of Medicine, will be in charge.

PINEL HOSPITAL TO EXPAND. Plans are now under way for immediate construction of an addition to Pinel Foundation, nonprofit hospital for treatment of mental illness. The announcement was recently made by Mr. George E. Fahey, president of the board of trustees, at a special board meeting at the Northwest Clinic of Psychiatry and Neurology. The addition will add eight private rooms and three double rooms to the present structure at 2318 Ballinger Way, Seattle.

Hospital Staff Meetings

DEACONESS HOSPITAL, SPOKANE. Ninety-five staff physicians were present at the regular monthly meeting of the medical staff of Deaconess Hospital, Tuesday, February 13. Reports of the obstetrical and surgery committees were read. Robert S. Jaggard, intern, presented a paper on Cerebral Oxygen Supply. During any anesthetic procedure, he said, whether general, spinal or local, the oxygen supply to the brain must be continued unimpaired. Obstruction to the airway may occur in one or more of several ways, such as foreign bodies in the trachea, oropharynx or glottis; bronchiolar constriction; alveolar obstruction; laryngospasm; heavy gauze masks; sunken lips of a patient with no dentures; snoring, or laryngeal edema. The disadvantages of a partially obstructed airway were mentioned as three-fold: The patient has to work harder to breathe, it is harder to get even anesthesia, and the supply of oxygen and the removal of carbon dioxide are impaired.

Gilman E. Sanford was admitted to the active staff

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and Albert S. Wiland to the senior courtesy staff. Richard D. Reekie, president of the medical staff, announced that the annual dinner meeting would be held March 13, 1951, at the Spokane Hotel.

Woman's Auxiliary

KITSAP COUNTY. Discussion of plans for the annual public relations tea scheduled March 28 constituted the major business of the auxiliary to the Kitsap County Medical Society meeting at the home of Mrs. J. T. Coyle, January 8, in Bremerton. Hostesses assist-

ing Mrs. Coyle were Mrs. C. W. Biedel and Mrs. James Carter.

GRAYS HARBOR. The Grays Harbor Medical auxiliary held a dinner meeting January 17 at the home of Mrs. William Hardy, Aberdeen. Assistant hostesses were Mrs. A. E. Anderson, Mrs. B. O. Swinehart, Mrs. Robert Harriage and Mrs. M. F. Fuller. Dr. Leonard Semler of Hoquiam spoke on the atomic bomb and Mrs. M. P. Graham traced a history of the auxiliary since 1930.

State Health Council

Spotlight on Service

Notes on activities of Washington physicians who volunteer time and effort beyond their regular activities to work with health councils, voluntary health agencies and in other ways to promote better general health. These notes are prepared for NORTHWEST MEDICINE by the Washington State Health Council.

Renton Doctor Sparks Success of Diabetes Drive

D. J. Laviolette of Renton was a real sparkplug in the Renton Health Council's observation of National Diabetes Week. The council sponsored a program to give diabetes tests to all high school students. A total of 1848 were tested. Dr. Laviolette gave freely of his time and abilities to make Renton's observance outstanding.

He was named medical advisor to the program by Lester J. Palmer of the Diabetes Association—and went a step further by bringing Dr. Palmer down to address two student assemblies. He also participated in a radio interview with a local junior-high diabetic patient and his mother, and cleared all press, radio and other material for medical accuracy.

Testing went on for three days and Dr. Laviolette was present each day to see that things ran smoothly. He helped obtain laboratory technicians from local labs and hospitals to run part of the tests at the high school. He explained the campaign to the local medical men, detailing the follow-up that would be needed when students with apparent symptoms came to them when test results were in.

State Health Council to Study Major Health Problems

L. E. Powers of the university's department of public health and preventive medicine, has been named by the State Health Council to head an important group to evaluate Washington's major health problems. The Washington State Health Council, a group of twenty-two state-level agencies providing health services, has asked Dr. Powers to name a study committee which will:

1. List the leading causes of death and illness (including disability and accidents) in this state.
2. List with each the groups and organizations having a program to deal with or remedy the problem.
3. Evaluate the adequacy of present services, and point out the most pressing unmet needs.

Charles E. Watts of Seattle, president of the Council, says the results of Dr. Powers' committee will be of extreme importance in guiding the future activities of the State Health Council in taking leadership to

fill in the gaps in our present health services. The Council also named two other long-range study committees, one on School Health Services, to be headed by Mrs. Edythe Tucker of the Washington Association of Local Health Councils, and another on The Handicapped Child, to be led by Mr. W. J. Bryan Hankins, executive director of the Washington Society for Crippled Children and Adults. Dr. Watts says physicians with special experience in these fields will be called on to serve on all three study committees.

Plan Endocrinology Conference

Lester J. Palmer, Seattle physician who is president of the American Diabetes Association, has been working with Robert H. Williams of the university medical school for a top-ranking postgraduate conference in the diagnosis and treatment of glandular diseases. About 300 doctors are expected from all parts of North America for the one-week session beginning July 1.

Epilepsy Clinic Established in Seattle

One of half a dozen Seizure Clinics in the U. S. for the diagnosis and treatment of epilepsy victims has been established in King County Hospital, Seattle, by the Washington Society for Crippled Children and Adults and the university medical school. Arthur A. Ward heads this program, which offers the services of a clinic team of neurosurgeon, neurologist, psychiatrist and a specialist in encephalography. Private patients may obtain information through the clinic about practicing physicians who specialize in this work, while indigent patients may obtain treatment on a free or part-pay basis. Dr. Ward is chief of the division of neurosurgery at the university medical school.

Additional Methods of TB Case-Finding Suggested

Donal R. Sparkman believes that mass radiographic chest x-ray surveys should be supplemented by two additional methods of case finding. Writing in the *Health Pilot*, publication of the Washington Tuberculosis Association, he says that all general hospitals should routinely x-ray every patient admitted. Dr. Sparkman says that the percentage of clinically significant tuberculosis found in hospital admissions is several times that of tuberculosis found in surveys of the general population. In addition, this move protects the health of the staff and of other patients. Sparkman also feels that private physicians should x-ray more of their regular patients and that this could be more widely done if some central, inexpensive photo-fluorographic service were available. Sparkman is a Seattle

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physician who is active in voluntary agencies in both the heart and tuberculosis fields. He is also vice-president of the Washington State Health Council.

Licensing and Inspection of Maternity Homes and Nursing Homes

At the present time maternity homes are being licensed by the State Department of Health under Chapter 214, Laws of 1943, and nursing homes, along with other so-called places of refuge, are being licensed by counties and cities under the Place of Refuge Act, Chapter 70, Laws of 1943, as amended by Chapter 100, Laws of 1945.

In September, 1950, a meeting of representatives of various interested and affected organizations and groups was called by the acting state director of health to discuss the need for changes in these laws and to plan legislation to meet the needs. At this meeting it was pointed out that our present maternity home licensing law is not administratively sound or enforceable; that it has been interpreted by the attorney general as a revenue raising act and requires the state director of health to issue a license upon request and payment of the \$25 fee; that the state director of health cannot withhold a license or require that maternity homes comply with proper standards; that some such homes should not be licensed since they do not meet proper standards; that there is no penalty in the event the rules and regulations for maintaining and operating maternity homes adopted by the state director of health are not met; that the chief purpose for which the law was passed, that of safeguarding the health and safety of mother and child, is not being accomplished. After discussion, it was unanimously agreed that this law should be

amended in order to make it enforceable, permitting penalties in the event of non-conformance with the requirements of the law and rules and regulations of the State Board of Health and providing for effective administration. It was further agreed that the State Board of Health proceed to draft an amendatory bill after which it would be submitted to the representatives of the various organizations and groups for their consideration.

Relative to the licensing of nursing homes it was brought out by the discussion at this meeting that the Place of Refuge Act is enforced quite effectively in a few of our larger counties, less effectively in a few others, and either very poorly or not at all in many of the remainder; that, if we are to stimulate hospitals toward good chronic annexes or wards and reliable agencies and individuals to develop good nursing homes, they need protection from unfair substandard competition.

Following discussion there was general agreement on the need for amending our present law providing for the inspection and licensing of nursing homes and on the matter of establishing uniform standards, rules and regulations on a state-wide basis; the latter to be drafted and adopted by a central authority such as the State Department of Health after consultation with the various interested and affected organizations and groups.

In accordance with the recommendations as to need and essential provisions agreed upon at this meeting proposed bills for licensing maternity homes and nursing homes have been drafted and approved by the various interested and affected organizations and groups for presentation to our present Legislature.

Announcements of Meetings

Second Annual Convention of Practical Nurses

Attendance of approximately 500 practical nurses is expected in Yakima at the Donnelly Hotel at the second annual convention of the Washington State Practical Nurses Association, March 29-31.

K. L. Partlow, president of the Washington State Medical Association, will be guest speaker. Keynote of the convention will be education. Interest will center on what constitutes a practical nurse, how licenses are acquired and legislation now current in the State Legislature. Considerable discussion will be devoted to the equivalency clause adopted by the Washington State Board of Examiners for practical nurses, at a meeting on October 7, 1950, as follows:

"... has completed 36 months of experience within the last five years, doing bedside nursing in hospitals.

This experience shall have been completed prior to October 1, 1950; evidence of completion of experience to be submitted to the Board on forms as required by the Board. Evaluation of each application will be made by the Board before acceptance to take the State Board examination. This provision shall expire on June 1, 1951."

Eligibility for the examination has previously been limited to graduates of an accredited school of practical nursing.

There are 3,000 registered practical nurses in the State of Washington, of which approximately 1,000 are members of the Washington State Practical Nurses Association. Officers of the association are Mrs. Mable Lane, Port Angeles, president; Mrs. Hilda Jones, Tacoma, vice-president; Mrs. Pearl Faunce, Bremerton, secretary; Mrs. Vera Culver, Bremerton, treasurer, and Mrs. McMahon, Seattle, executive secretary.

The Washington State Obstetrical Association

Affiliated with

NATIONAL FEDERATION OF OBSTETRIC & GYNECOLOGIC SOCIETIES

and

AMERICAN COMMITTEE ON MATERNAL WELFARE, INC.

SPRING MEETING

**Saturday, April 7, 1951—Washington Athletic Club
Seattle, Washington**

GUEST SPEAKERS



RUSSELL DE ALVAREZ
Professor of Obstetrics and Gynecology
University of Washington School of Medicine



L. M. RANDALL
Professor of Obstetrics and Gynecology
Moyo Foundation



HOWARD C. STEARNS
Professor of Obstetrics and Gynecology
University of Oregon Medical School

Program

- | | |
|--|--|
| 9:30 Registration | 3:30 Dr. Howard C. Stearns |
| 10:00 Dr. L. M. Randall | "Obstetrical Anesthesia" |
| "Experiences With the Test of Labor" | 4:30 Round Table |
| 11:00 Dr. Howard C. Stearns | Dr. Russell de Alvarez, Moderator |
| "Concepts and Fundamental Factors of Prenatal Care" | 5:30 Business Meeting |
| 12:00 Luncheon and Symposium | 6:00 Cocktail Hour |
| Dr. Russell de Alvarez, Moderator | 7:00 Banquet and Symposium |
| 1. Management of prolonged labor | Dr. Russell de Alvarez, Moderator |
| 2. Management of the past term "overdue" patient | 1. X-ray pelvimetry and fetometry |
| 3. Management of vaginal infections during pregnancy | 2. Management of breech presentations |
| 2:30 Dr. L. M. Randall | 3. Virus Diseases and use of immune globulins in the first trimester |
| "Practical Approach to the Diagnosis of Functional Disorders of the Genital Tract" | |

Registration limited to 125. Association members given priority up to April 1.
Non-members' applications accepted in order of receipt.

REGISTRATION

Washington State Obstetrical Association

SPRING MEETING, APRIL 7, 1951

WASHINGTON ATHLETIC CLUB, SEATTLE, WASHINGTON

Enclosed is registration fee, \$8.00, for the spring meeting (includes Luncheon and Banquet), and is refundable upon notification prior to meeting date.

Attached is my question for round table discussion

(Signed)

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E. G. LAYTON, M.D., 805 Medical and Dental Building, Seattle 1, Washington.

University of Washington School of Medicine

MEDICAL DEANS SEE EWING BEHIND THE RUSK REPORT. Deans from a number of medical schools met in Chicago early in February and most of them attended the National Congress on Medical Education and Licensure held under auspices of the American Medical Association's Council on Medical Education and Hospitals, February 11 and 12. At that meeting they heard Howard Rusk give his report on what his committee thinks the country needs in the way of medical manpower during the next few years. The deans were somewhat more impressed by Rusk's hysteria than by Rusk's figures. To the latter they applied a moderate-sized dose of sodium chloride before returning with them to their schools in all parts of the country.

So much is gathered from a report, couched in more dignified terms, that Dean E. L. Turner gave to a special meeting of the faculty of the University of Washington School of Medicine, February 26.

According to Dr. Turner, the Health Resources Advisory Committee of the National Securities Resources Board, headed by Rusk, is urging the medical schools of the country to expand and to accelerate. By expansion is meant the acceptance of about 15 per cent increase in enrollment. By acceleration is meant the reduction in medical school years from four to three. Thus the Rusk committee is urging quantity production of physicians. The deans are more than moderately skeptical as to how the quality will be maintained under such a program. They expressed themselves in no uncertain terms. They called the Rusk report fantastic.

Rusk says that by 1954 there will be a shortage of 22,000 physicians unless his demands are complied with. This is based on requirement of 183,700 physicians for the civilian population and 18,500 for the armed forces, plus several other so-called needs. Among the latter are 1,800 assigned to industry and rehabilitation (Dr. Rusk is a rehab specialist) and 3,300 for civil defense. The latter figure drew a derisive snort from the deans. Mostly of a practical turn of mind they felt that civilian doctors would undoubtedly do most of the civil defense work in any real crisis and that Rusk's assignments would probably do a big job of chair warming.

The deans were also quick to point out that Rusk's

figure of 183,700 physicians for civilian medical service was based on a ratio of one physician to 850 persons. They know full well that this ratio can be raised to considerably higher levels without endangering civilian medical care. During World War II it went to 1,350 while the armed services had one physician for every two hundred men. Since there have been so many complaints about wastage of medical manpower by the armed services this excessively high ratio may be reduced during the present emergency.

Dr. Turner also told the faculty that Rusk had failed to recognize the fact that the medical schools of the country had already expanded to an amazing extent. At the present time there are 26,193 medical students in this country, a figure which is 1,090 over that of only one year ago and about 5,000 more than ten years ago. Dr. Turner pointed out that this is fully equivalent to the opening of fifteen new medical schools with average freshman classes of 75 men each.

The Association of American Medical Colleges has studied the problem of curriculum changes almost constantly since it was organized. It faces the tremendous and accelerating growth of medical knowledge with the firm conviction that curricula can be cut only so far without destroying the quality of basic medical education. It has, therefore, recommended that the course of medical education consist of four years of twelve months each. Acceleration would be ruinous to American medicine.

Dean Turner reported to the faculty that after Rusk presented his report the group of deans began to study his references. Considerable light began to dawn when it was discovered that the major part of the Rusk figures came straight from the calculations of the same individuals who played such a prominent role in preparing figures for Oscar Ewing's campaign to socialize American medicine. Thus they see once more the fine hand of the ubiquitous Mr. Ewing.

The deans, through their Executive Council of the Association of American Medical Colleges (which met just prior to the National Congress on Medical Education and Licensure) have joined with the Council on Medical Education and Hospitals to name a committee to study the problem. This joint committee will go to Washington, D. C., to investigate the figures presented by Rusk. Their report will be interesting.

IDAHO STATE MEDICAL ASSOCIATION



**ANNUAL MEETING
JUNE 17-20, 1951
SUN VALLEY**

President, R. T. Scott, M.D., Lewiston

Secretary, R. S. McKean, M.D., Boise

Executive Secretary, Mr. A. L. Bird, Boise

Medical Notes

The program for the 59th annual meeting of the Idaho State Medical Association, Sun Valley, June 17, 18, 19 and 20, is rapidly taking shape. Program

Committee Chairman Alexander Barclay, Coeur d'Alene, reports that five outstanding speakers have accepted invitations to address the scientific sessions.

Names, background subjects and other information will be announced soon.

This year's sessions will be streamlined, scientific sessions to be held in the Opera House from 9:30 a. m. until 1 p. m. No round-table luncheon sessions planned. Guest speakers will participate in a question and answer session on the afternoon of June 20 in the Opera House. House of Delegates will meet on Sunday, June 17, to transact as much business as possible. Committee chairmen will be asked to present five-minute summaries on activities of their committees. Complete reports to be filed with the secretary.

Festivities are planned for each evening. The annual banquet on June 20 will be unusually outstanding, Dr. Barclay reports.

Resolution committee appointed. President Russell T. Scott has appointed Frank Fletcher, 311 West Idaho St., Boise, as chairman of the Resolutions Committee. Other members include Charles Beymer, Twin Falls, and Melvin M. Graves, Pocatello. Resolutions to be presented to the House of Delegates must be in the hands of Dr. Fletcher not later than June 12.

Remember the dates, June 17, 18, 19 and 20, 1951. Sun Valley. Plan to be there!

The Idaho Heart Association, formed during the past year by members of the association's Cardio-Vascular Committee, has been approved by the American Heart Association. The following is a report from Paul F. Miner, president of the Idaho Association:

The Idaho Heart Association, whose organization is sponsored by the association's Cardio-Vascular Committee, recently received word of their acceptance as an affiliate by the American Heart Association. The committee has felt that any heart organization should be organized and sponsored by a professional rather than a lay group. Any member of the A. H. A. residing in the state is a member of the Idaho Association by virtue of the affiliation acceptance. The membership will be open to both professional and lay persons. The finance committee will meet soon to decide on the exact amount of annual dues which probably will be one or two dollars. Dues for the monthly scientific bulletins of the American Heart Association will be additional and optional.

The Idaho Heart Association will cooperate with the American Heart Association in the financial campaign during February. This campaign will be largely limited to distribution of plastic hearts in public places with newspaper publicity and use of radio programs sponsored by the A. H. A.

Seventy-five per cent of the money raised in the state remains with the Idaho Association to be used in the state. It is anticipated that a good portion of these funds will be used to provide speakers for medical meetings and in aiding research projects in medical schools in neighboring states.

Last May a seminar on cardio-vascular diseases was held in Boise for a small group of physicians and was financed by the State Department of Public Health. From experience gained at this meeting it has been felt that the Idaho Association could finance speakers for similar meetings for all the physicians each year. It is hoped that such a meeting can be arranged around May 1. Details of such a meeting will be announced in a future News Letter.

Contributions to the organization should be made to Mr. William Goodall, treasurer, care of Continental State Bank, Boise, Idaho. Physicians aiding in the Idaho campaign include: Dr. Henry Smith, Idaho Falls; Dr. George E. Brown, Jr., Twin Falls; Dr. Richard Howard, Pocatello, and Dr. Burton Stein, Lewiston.

State Board of Medicine's regular session was held in Boise, January 8, 9 and 10. Four candidates wrote the examination and received passing grades. They included: Vaughn M. Pond, Salt Lake City, Utah, University of Chicago School of Medicine, Chicago; Walter W. Fallon, Charles M. Lindsay and Carl U. Albertson, all of Salt Lake City, Utah, University of Utah School of Medicine.

Licenses without examination were granted to: Robert F. Barter, Mackay, Idaho, Indiana University School of Medicine, Bloomington, Ind.; Barry Severn Seng, Gooding, Idaho, and Walter E. Anderson, Gooding, Idaho, both of Northwestern University School of Medicine, Chicago, Ill.; Mitchell B. Rider, Twin Falls, Idaho, University of Colorado School of Medicine, Denver; Edward B. Webb, Pocatello, Idaho, Jefferson Medical College School of Medicine, Philadelphia; John E. Rockwell, Jr., Stibnite, Idaho, Louisiana State University School of Medicine, New Orleans; Herbert W. Anderson, Twin Falls, Idaho, State University of Iowa School of Medicine, Iowa City.

Jack C. Reines, Arco, Idaho, University of Louisville School of Medicine, Louisville; Eli C. Openshaw, Carey, Idaho, College of Physicians and Surgeons, Little Rock, Ark.; Thomas James Durkin, Boise, Idaho, University of Alberta, Faculty of Medicine, Edmonton; Grant A. Hawkes, Hailey, Idaho, University of Utah School of Medicine, Salt Lake City; Lloyd H. Jennings, Twin Falls, Idaho, University of Iowa School of Medicine, Iowa City; Henry Hirsch, San Bernardino, Calif., and Earl C. Mercill, Los Angeles, Calif., College of Medical Evangelists, Loma Linda; Frank L. Abbey, State Hospital South, Blackfoot, Idaho, George Washington University School of Medicine, St. Louis; E. J. Nitschke, Portland, Oregon, McGill University, Faculty of Medicine, Montreal; Jack R. Carey, Idaho Falls, Idaho, Northwestern University School of Medicine, Chicago; Robert H. Schaeffer, Lewiston, Idaho, University of Oregon Medical School, Portland; Clifford G. Weston, New Jersey, College of Physicians and Surgeons, Columbia University, New York City; David J. McKay, San Leandro, Calif., Stanford University School of Medicine, San Francisco, and Royal S. Cutler, Sun Valley, Idaho, University of Rochester Medical School, Rochester, N. Y.

Two members of the State Board of Medicine, Chairman S. M. Poindexter and W. B. Ross, attended the Forty-seventh Annual Congress on Medical Education and Licensure in Chicago, February 11-13.

The next regular meeting of the State Board of Medicine will be held in Boise beginning July 8.



ALASKA TERRITORIAL MEDICAL ASSOCIATION



ANNUAL MEETING Ketchikan, May 31-June 2, 1951

President, D. Cramer, M.D., Ketchikan

Secretary, W. P. Blanton, M.D., Juneau

Medical Notes

Construction of a \$1,860,000 building to house staff members of the new federal hospital in Anchorage is scheduled to start this spring, according to Max Boyer, project engineer with the Interior Department. Contracts will be awarded this winter so that actual construction can be started with the spring breakup, he said. The building will provide 78,000 square feet of space in a three-story concrete and steel structure. It will house nurses, single professional and technical help. The structure will be immediately to the west of the present huge main building which dominates the Anchorage skyline in the eastern part of the city.

The Alaska Public Works office in Juneau announces applications for several hospital building projects in the territory. Preliminary plans are completed for structures at Cordova, Sitka and Craig, planning has begun for buildings at Petersburg and Craig, and plans are expected soon for a structure at Valdez.

Another project involves construction of an infirmary at the University of Alaska at an estimated cost of \$157,000.

William P. Blanton, secretary of the Alaska Territorial Medical Association, reports the following new

members for 1951: J. Donald Wentzler, Ketchikan; Chester L. Schneider, Glennallen; W. C. Mathews, Anchorage; Raymond B. Coffin, Cordova; John Stuart, Juneau; Edward H. Dunn, Tanana, and George E. Hale, Anchorage. Dr. Blanton expects soon to make his annual visit to Seattle and has promised to call at the offices of NORTHWEST MEDICINE with more news from Alaska.

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Postgraduate Courses

University of Washington School of Medicine

Postgraduate Course in Gynecology, April 2-5, 1951

This four-day course will be devoted entirely to a presentation of gynecologic problems as they pertain to general practice, as well as to the specialized practice of gynecology. It will embody considerations of office gynecology, diagnostic methods, and gynecologic endocrinology, as well as operative gynecology. The course is being so planned as to avoid repetition of the subjects to be covered in the General Practice Clinic Day on April 6 and the Washington State Obstetrical Society meeting on April 7. Tuition fee: \$40.00.

Oregon Academy of Ophthalmology and Otolaryngology

Twelfth Annual Spring Convention in Ophthalmology and Otolaryngology

March 25-30, 1951, Portland, Oregon

There will be two separate programs. The ophthalmology lectures and demonstrations will be held all day Monday and Tuesday and Wednesday morning. The otolaryngology lectures and demonstrations will be held Wednesday afternoon and all day Thursday

and Friday. You may register for one or both programs. The fee for either one is \$50; for both it is \$75.

Guest speakers will be Richard G. Scobee, Associate Professor of Ophthalmology, Washington University Medical School, St. Louis; F. Bruce Fralick, Professor of Ophthalmology, University of Michigan Medical School, Ann Arbor; Theodore E. Walsh, Professor and head of the Department of Otolaryngology, Washington University Medical School, and Maurice H. Cottle, Professor and head of the Department of Otolaryngology, Chicago Medical School, Chicago.

Michael Reese Hospital Postgraduate School

April 2-7, 1951, Chicago, Ill.

The Michael Reese Hospital Postgraduate School is offering a one-week course in Clinical Dermatology—refresher course in diseases of the skin for general practitioners. Clinics and lectures will be conducted by the members of the Department of Dermatology and Syphilology.

April 9-14, 1951

A one-week course will also be offered in Surgery—Indications, Pre- and Postoperative Care. Clinical and



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didactic material in this full-time course will be presented by members of the Department of Surgery and cooperating departments. For further information concerning the above courses, address: Dr. Samuel Soskin, Dean, 29th St. & Ellis Ave., Chicago 16, Ill.

University of Pittsburgh School of Medicine

April 24-28, Hotel Roosevelt, Pittsburgh, Pa.

This course on Diseases Due to Allergic and Immune Mechanisms is intended for those interested in internal medicine and in allergy. It will convey an understanding of what has developed recently in the field of Applied Immunology, Biochemistry, Hormonal Relations, Immunochemistry and the basic mechanisms of allergic reactions. All registrations are handled

through the central office of the American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa.

International Academy of Proctology

Teaching Seminar in Proctology

April 7, 1951, New York City

The International Academy of Proctology will present its first teaching seminar on proctologic subjects, including the more recent developments, in the form of a symposium and round-table discussion. Preference in registration will be given to those affiliated with the International Academy of Proctology. For registration or further information communicate with Dr. William Lieberman, Chairman, Seminar Committee, International Academy of Proctology, 1819 Broadway, New York 23, N. Y.

Book Reviews

THE NORMAL ENCEPHALOGRAM. By Leo M. Davidoff, M.D., Director of Neurological Surgery, Beth Israel Hospital, New York City; Clinical Professor of Neurosurgery, New York University Postgraduate Medical School. And Cornelius G. Dyke, M.D., Late Associate Professor of Radiology and the College of Physicians and Surgeons, Columbia University; Institute of New York. Third Edition, thoroughly revised by Leo M. Davidoff, M.D. 190 Illustrations on 156 figures. 240 pp. Price \$6.00. Lea & Febiger, Philadelphia, 1951.

"The object of this book is to present a fundamental thesis on encephalography based not only on our experience with 4000 cases but also a review of the literature. The material covered includes a description of the technique, indications and contraindications for the performance of the test, reaction of the patient during and after the procedure."

This volume presents a striking collection of photographs and roentgenograms of the normal brain. These contain information which will prove a revelation to those unfamiliar with the details of normal brain anatomy. Specifications are outlined in the various roentgenograms with explanations revealing a multitude of details. If one is rusty on his recollections of brain anatomy, he can acquire a wealth of useful information by careful reading of this book. It is highly recommended.

PHYSICIANS' AND NURSES' CONCISE MEDICAL ENCYCLOPAEDIA. By William H. Kupper, M.D., author of "Malarial Therapy," "State and National Board Summary," "Interesting and Useful Medical Statistics." 450 pp. Price \$7.50. Biblion Press, Los Angeles, Calif., 1950.

"This concise medical encyclopaedia is an attempt to bridge the gap between medical dictionaries which say too little about too much, and the medical tomes which say too much about too much—too often in microscopic type which can be read only by schoolboys whose accommodations are not yet blessed with the dignity of presbyopia."

This volume is an amplification of this quotation. It is intended for handy use of doctors and nurses, supplanting the ordinary medical dictionary which often contains a multitude of material which is often more or less superfluous. In this volume the contents are arranged in groups, beginning with each letter of the alphabet. Only matter essential to the topic is introduced. Accordingly, it should be a handy volume for office use, containing only essential information on individual subjects.

THE PHYSICIAN EXAMINES THE BIBLE. By C. Raimer Smith, B.S., M.D., D.N.B. 394 pp. Price \$4.25. Philosophical Library, New York, 1950.

More copies of the Bible have been published in past years and are printed every year than any other book. Copies are printed and circulated in all languages of the world. Such a statement cannot be made of any other book that has ever been written.

"The Hebrews, unlike their neighbors, the Egyptians and Babylonians, left no medical literature per se, but the Bible contains many references pertaining to medical subjects, especially the laws referring to personal and social hygiene. These subjects should be of great interest to all Bible students."

This statement is illustrated by the contents of this volume. All Bible students know that this greatest of all books contains a multitude of references to illnesses and their treatments which are antiquated and useless in the face of modern medical knowledge and practice. Nevertheless, knowledge concerning them is of great interest, whatever may be the individual's convictions regarding Biblical teachings. This book can be recommended for anyone interested in the medical references and principles presented in this Book of Books.

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DOCTOR COME QUICKLY. By Frank J. Clancy, M.D. 248 pp. Price \$2.95. Superior Publishing Co., Seattle, 1950.

The author of this book spent all of his boyhood and subsequent years in Seattle with the exception of a period during the Klondike excitement, when he lived with his parents in the gold mining regions. He was a graduate of the University of Washington and studied medicine at University of Oregon Medical School, from which he graduated in 1918. With the exception of a period of service in the Navy and later an engagement with the American Medical Association in Chicago, his practice has been continuous in Seattle. His specialty has been genitourinary practice, in which he has attained proficiency and distinction.

In this volume are presented many incidents from the author's experiences in medical practice. They include amusing and interesting events in the life of a busy practitioner. They are recorded in a realistic manner which offers entertainment to any reader of this volume. As is true in all autobiographies, there are many personal experiences described which are of special interest to the author, many of which are entertaining to the general reader.

DIATHERMY. THE USE OF HIGH-FREQUENCY CURRENTS. By Stafford L. Osborne, B.P.E., M.D., Ph.D., Professor and Chairman, Department of Physical Medicine, Northwestern University Medical School. 113 pp. Price \$3.00. Charles C. Thomas, Publisher, Springfield, Ill., 1950.

Diathermy has become an established feature in medical practice. Every physician finds this more or less a necessity and must inform himself concerning its applications and results. This book contains many suggestions and descriptions of the applications of this form of treatment and is therefore recommended for the careful perusal of every physician who desires the latest information concerning its employment.

FREUD: DICTIONARY OF PSYCHOANALYSIS. Edited by Nandor Fodor, Associate of the Association for the Advancement of Psychotherapy, and Frank Gaynor, co-author of the "Dictionary of Industrial Psychology." With a Preface by Theodor Reik, author of "Listening With the Third Ear." 208 pp. Price \$3.75. Philosophical Library, New York, 1950.

Freud died in London about 11 years ago. "Fortunately, we have the possibility to study his work in the original. To remain within the simile, he has left us a magnificent self-portrait in those thirteen volumes of his writings.

"Some analysts, known as specialists in Freudian quotations, have been receiving constant requests to supply references to those who sorely needed them. This book will safeguard them from the penalty of specialization and will place all Freudiana within easy reach of professional and non-professional researchers."

This book consists entirely of Freudian quotations, assembled under letters of the alphabet. They comprise a convenient opportunity of noting Freud's views on a great variety of subjects. If one desires information or the opportunity of quotations from his writings, this volume will furnish abundant material for securing such desired quotations.



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RENAL DISEASES. By E. T. Bell, M.D., Professor of Pathology in the University of Minnesota, Minneapolis, Minn. Second Edition, thoroughly revised, with 123 illustrations and four-color plates. 448 pp. Price \$6.00. Lea & Febiger, Philadelphia, Pa., 1950.

This is a well-printed, concise book by one of the recognized authorities on renal disease. The author has not attempted to make this a reference book for all problems of renal disease; rather, it is a quick and handy summary of his extensive experience and a resume of some of the recent literature, for use by busy doctors. The author has attempted to keep discussion of most disease processes to the minimum, compatible with clarity, and in most instances he has done so quite well.

The discussion of glomerulonephritis is clear and concise. The illustrations and photomicrographs throughout the book are unusually fine. The section on "Lower Nephron Nephrosis" is only one page long and the author expresses several objections to the use of the term and to the concept of this syndrome. This form of tubular disease may deserve a more complete treatment. Only one reference is given.

Discussion of potassium retention in various types of renal disease is mentioned briefly. Pylonephritis, toxemias of pregnancy and essential hypertension are capably presented in an interesting manner.

This is a concise, handy book for rapid reference which should be in all medical libraries and in the private libraries of all physicians who desire to further their knowledge of renal diseases.

ROBERT W. SIMPSON

COMMUNICABLE DISEASES, Edited by Roscoe L. Pulen, A.B., M.D., F.A.C.P., Professor of Graduate Medicine, Director of the Division of Graduate Medicine and Vice-Dean of the School of Medicine, Tulane University of Louisiana, etc. 1035 pp., 253 figures, 35 illustrations on 20 color plates. Price \$20. Lea & Febiger, Philadelphia, Pa., 1950.

In this volume are presented 54 of the more common communicable diseases encountered and six "exotic" conditions. Each subject is presented by a person well-qualified by experience to give well-rounded, authoritative and recent information about the disease concerned.

The book is divided into nine sections under the following headings:

1. Introduction to the communicable diseases. This is quite comprehensive and general in character, presenting various diagnostic approaches, information concerning management of these diseases in regard to precautionary isolation or quarantine measures, general therapeutic agents, treatment measures and ending with general preventive or prophylactic measures.
2. Communicable diseases with predominant skin manifestations.
3. Communicable diseases with predominant respiratory manifestations.
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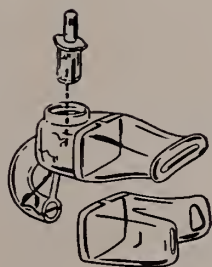
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7. Communicable diseases with predominant enteric manifestations. This is largely devoted to acute diarrheal disorders, such as found in shigellosis, salmonellosis, food poisoning, etc. It includes botulism which involves primarily the central nervous system and seldom produces enteric manifestations but probably was placed in this group because of its relation to food poisoning.
8. Communicable diseases of parasitic origin.
9. Communicable diseases capable of becoming a potential menace. The diseases in this group are seldom encountered in this country but a useful purpose is served in having presentations of such "exotic" diseases included in a book of this type.

The material in the book is excellent and well-illustrated. It should be of real value to physicians in general practice, periatrics or internal medicine as well as to public health officers.

W. R. GIEDT

SURGERY OF THE EYE—INJURIES. By Alston Callahan, B.A., M.S. (Ophth.), M.D., F.A.C.S., Professor of Ophthalmology, Medical College of Alabama, and Director, Thigpen-Cater Eye Hospital, Birmingham, Ala. Formerly Chief, Eye Section, Northington General Hospital, Tuscaloosa, Ala. 217 pp. Price \$11.50. Charles C. Thomas, Springfield, Ill., 1950.

This is an unusual type of book when compared with others on this subject. The author has been in position to care for a large number of traumatic injuries. His experience allowed him to try these methods often enough under favorable circumstances and, with the aid of antibiotics, to be able to judge adequately which procedures gave best results in his hands.

This book is not padded with methods which have not proven satisfactory but neither is it claimed that his chosen procedures are infallible. The author's series of colored plates and photographs are particularly impressive. Although many of the technics are described briefly, a careful review of the text and of the plates with their explanations makes most of the procedures clear to one who has been doing eye surgery.

The chapters on injuries of the cornea, conjunctiva and sclera, injuries of the lens, intraocular foreign bodies, traumatic separation of the retina do not offer a great deal that is not well covered in previous books on surgery of the eye but they do give the author's definite opinion of the technics he has chosen as best. The chapter on removal of the eye contributes his experience with some of the newer types of implants which have not been incorporated in previous books.

The major contributions are to be found in the remaining chapters on plastic repair of the adnexa by means of wiring, pedicle flaps, or direct skin and mucous membrane transplants. This difficult type of surgery he has explained and illustrated exceptionally well.

This book is worthy of a prominent place in the library of every ophthalmic surgeon who is engaged in traumatic surgery of the eye and adnexa, either in an industrial area or in the rear echelons during wartime.

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NURSING IN PREVENTION AND CONTROL OF TUBERCULOSIS. By H. W. Hetherington, M.D., M.R.C.P. (London), Chief of Clinic of the Henry Phipps Institute of the University of Pennsylvania; Assistant Professor of Medicine of the University of Pennsylvania School of Medicine; Former Visiting Physician to the White Haven Sanatorium. And Fannie W. Eshleman, R.N., B.S., Supervisor of Public Health Nursing of the Henry Phipps Institute of the University of Pennsylvania; Lecturer on Tuberculosis Nursing, Department of Nursing Education of the University of Pennsylvania. Illustrated with photographs and charts. Revised Third Edition. 361 pp. Price \$4.50. G. P. Putnam's Sons, New York, 1950.

This is the revision of a text written to provide the student nurse with general information and understanding of tuberculosis. It is well-organized, contains selected references and a questionnaire on each chapter. The various phases of tuberculosis such as diagnosis, prevention, clinic and public health management are well-covered, but in my opinion it does not fulfill its purpose as a revision because it has not adequately incorporated the advancements made in this field.

The material on mental therapy is a counterpart to that on mental rest in the 1941 edition. To state that "the mental attitude of the patient seems to have little to do with the disease itself" does not appear to show progression in attitude and thinking.

Likewise, the paragraph devoted to pneumoperitoneum is identical with that in the former editions despite its growing importance in collapse therapy. The same criticism applies to the lack of information regarding chemotherapy and the newer surgical procedures which are merely mentioned in a short paragraph entitled "Other Surgery."

EUGENIA STILLSON, R.N.

POSTGRADUATE LECTURES ON ORTHOPEDIC DIAGNOSIS AND INDICATIONS. By Arthur Steindler, M.D., F.A.C.S., Professor of Orthopedic Surgery, State University of Iowa, Iowa City, Iowa. Voluem 1, Section A: Propedeutics in Orthopedic Diagnosis. Section B: Congenital Deformities and Disabilities. 289 pp. Price \$7.50. Charles C. Thomas, Springfield, Ill., 1950.

This book starts out with discussion of the normal structure of the body and normal bony landmarks, including principles of correct posture and balance. It analyzes kinetics of joint motions with ranges of the various joints and mechanical changes taking place during these motions. These studies are fundamental and of the greatest importance in understanding and differentiating the normal from the abnormal.

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The second part of the book describes congenital deformities and disabilities. It describes the various types of growth abnormalities of bones with numerous illustrations of good quality. Subsequent chapters describe congenital deformities of the spine and thorax



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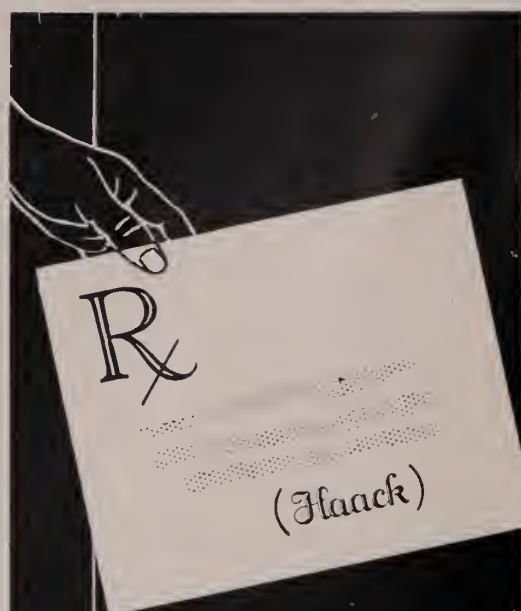
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in considerable detail. His chapter on clubfoot is excellent, with emphasis on the pathogenesis and pathologic anatomy. Likewise, considerable space is given to treatment. Another chapter describes anomalies of the long bones of the lower extremities. An entire chapter is devoted to congenital dislocation of the hip with excellent descriptions. The final chapter describes congenital deformities of the upper extremities.

A tremendous amount of information is crowded into a rather small book that is excellently illustrated. The first half requires detailed study in order to understand the terms and language in which he speaks but much information can be gleaned by carefully studying it.

J. IRVING TUELL

WORLD SURGERY, 1950. By Stephen A. Zieman, M.A., M.D., F.A.C.A., F.I.C.S., Abstract and News Editor *Journal of the International College of Surgeons*, Abstractor for International Abstracts of Surgery, and Surgery, Gynecology and Obstetrics. Formerly Assistant Chief, Bureau of Publication, U. S. Navy Medical Department, and Assistant Editor, *U. S. Navy Medical Bulletin*. 53 Illustrations. 177 pp. Price \$6.00. J. B. Lippincott Co., Philadelphia, London, Montreal, 1950.

"This volume is a survey of the world literature in surgery. The purpose of the editor is to give the reader the high points in general surgery chosen from surgical journals of practically every nation and every language and to put forth newer ideas, newer technics and newer claims for improvement and advancement of the theory and practice of surgery."

The contents include gastrointestinal surgery, cardiovascular-respiratory surgery, gynecology, obstetrics, orthopedics, genitourinary surgery, neurosurgery and psychosurgery, ophthalmology and otolaryngology, head and neck, and miscellaneous. Under these headings are published brief abstracts on a multitude of surgical topics from journals of all nations. This volume should be of interest to all surgeons.

THE PREPARATION OF PHOTOGRAPHIC PRINTS FOR MEDICAL PUBLICATION. By Stanley J. McComb, F.B.P.A., Section of Photography, Mayo Clinic, Rochester, Minn. 65 pp. Price \$2.00. Charles C. Thomas, Publisher, Springfield, Ill., 1950.

This is a very instructive booklet regarding correct and incorrect presentation of photographs and roentgenograms. Errors of over- and underexposure are illustrated. Anyone attempting to illustrate by either of these procedures will profit by reading the contents of this book.

VISUAL ANATOMY. HEAD AND NECK. By Sidney M. Friedman, M.D., Ph.D., Professor of Anatomy, University of British Columbia, Vancouver, Canada. Formerly Associate Professor of Anatomy, McGill University, Montreal, Canada. 217 pp. Price \$6.50. Charles C. Thomas, Publisher, Springfield, Ill., 1950.

This is a remarkable publication. Every left-hand page is descriptive of the illustration on the right-hand page. As indicated by the title, these illustrations and their descriptions cover in detail the anatomy of the head and neck. It offers a very convenient opportunity of obtaining anatomic information of these portions of the human anatomy in more detail and clarity than can be observed elsewhere.



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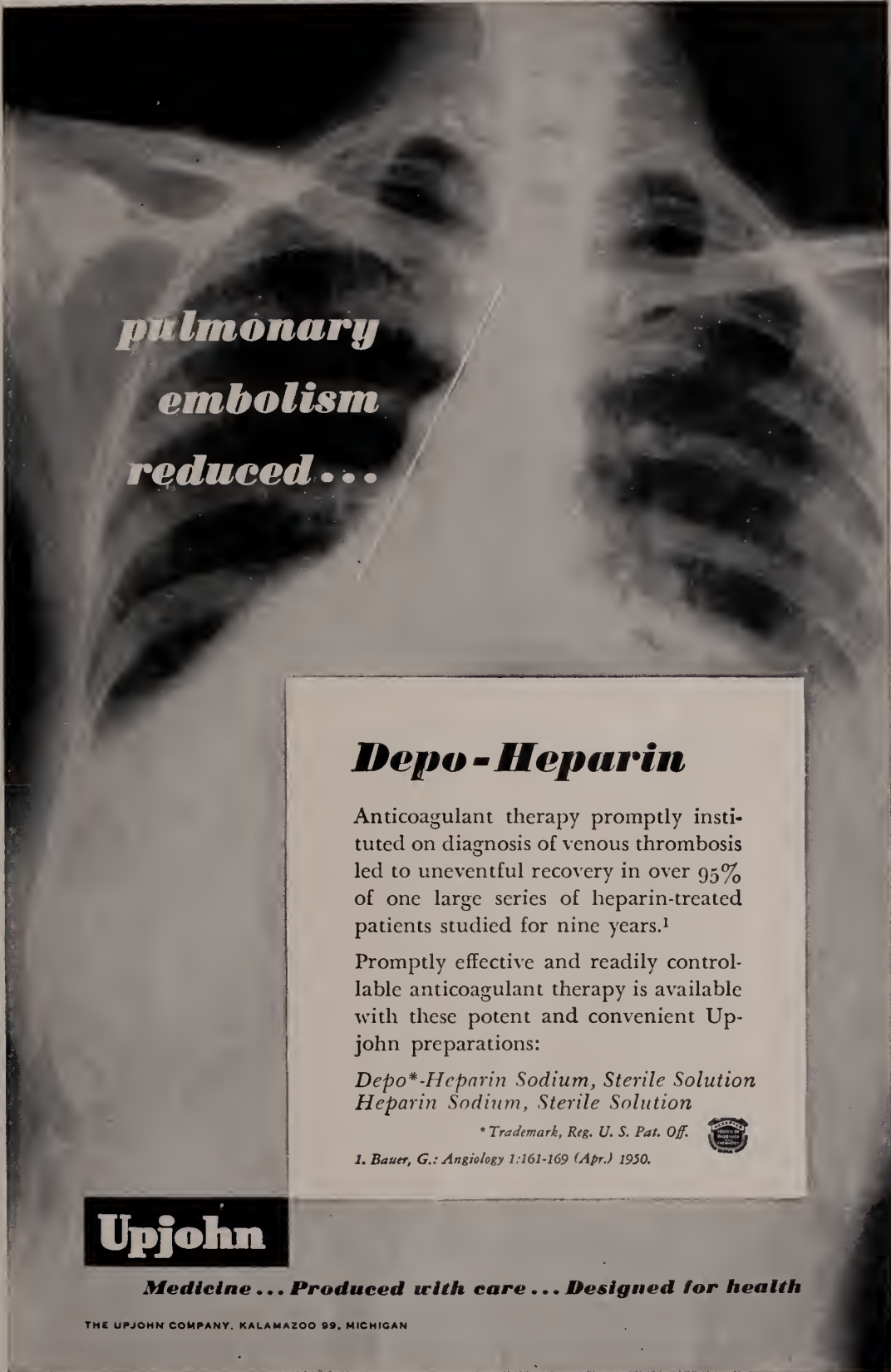
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1. Bauer, G.: *Angiology* 1:161-169 (Apr.) 1950.



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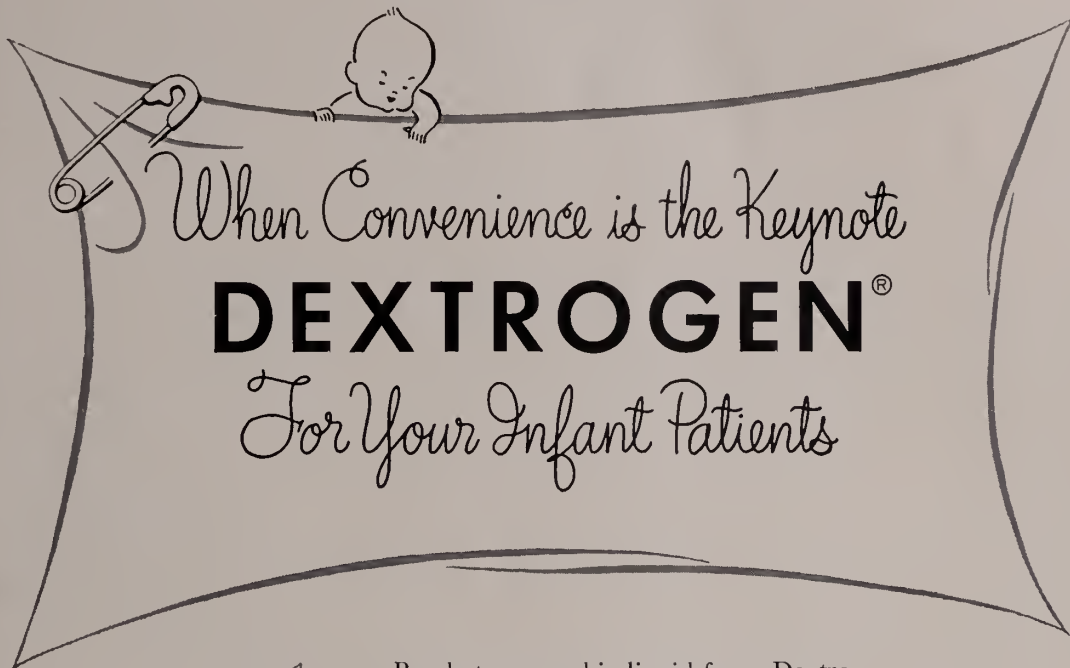


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CASE	DIAGNOSIS	INFECTING ORGANISM	DAYS TREATED	TOTAL DOSE GM.	ADMINISTRATION	CONDITION AND RESULT
16	Acute laryngotracheal bronchitis	Hemophilus influenzae	3	12	oral	Marked improvement in 24 hours. Recovery

Case report taken from Herrell, W. E.; Heilman, F. R., and Wellman, W. E.: *Ann. New York Acad. Sc.* 53:448 (Sept. 15) 1950

Terra

CRYSTALLINE

prompt response

in acute follicular tonsillitis

CASE	DIAGNOSIS	CULTURE		DAILY DOSE GM.	NUMBER OF DAYS TREATED	RESULT
		SOURCE	ORGANISM			
29	Acute follicular tonsillitis	throat	Streptococcus pyogenes	4	3	Prompt clinical response. No fever after 24 hours of treatment

Case report taken from Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. A.: *Proc. Staff Meet., Mayo Clin.* 25:183 (Apr. 12) 1950.

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Knight, V.: New York State J. Med. 50:2173 (Sept. 15) 1950.

"Three patients with beta streptococcic pharyngitis were treated and made a prompt recovery."

Dowling, H. F., Lepper, M. H., Caldwell, E. R., and Spies, H. L. Ann. New York Acad. Sc. 53:433 (Sept.) 1950.

"Terramycin (250 mg. every three hours) when given orally appears to be extremely effective."

Schenck, H. P.: M. Clin. North America 34:1621 (Nov.) 1950.

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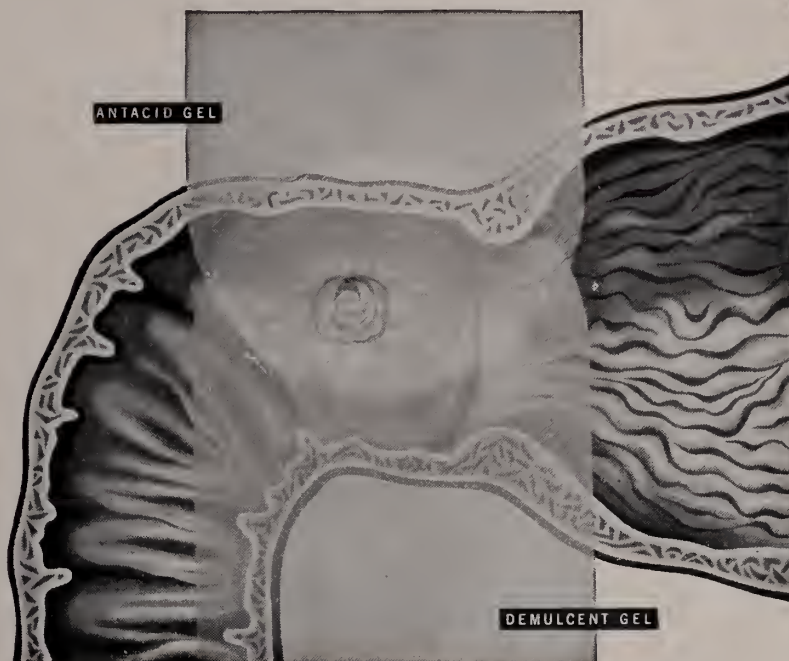
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**Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245; *N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592;
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

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King County Society President, D. Metheny Seattle	First Monday—Seattle Secretary, F. A. Tucker Seattle
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Klickitat County Society President, J. R. Rehal Stevenson	Secretary, D. G. Moody White Salmon
Lewis County Society President, Robert Fulton Chehalis	Second Monday—Centralia and Chehalis Secretary, Rush Banks Centralia
Lincoln County Society President, E. R. Salter Davenport	Secretary, J. E. Anderson Wilbur
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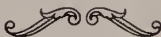
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Nervous tension and chronic anxiety, discharged through a labile Autonomic Nervous System, can cause somatic disturbance.^{1,2} Such states may involve any one of the organ systems or several at one time.^{1,3} The outline below is designed to relate gastrointestinal and cardiovascular symptomatology to the exaggerated response of the autonomic nervous system.

	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro-intestinal System	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio-vascular System	Rapid heart rate Peripheral vaso-constriction	Slow heart rate Vasodilatation
Functional Manifestations	Palpitation Tachycardia Elevated blood pressure Dry mouth and throat	Heartburn Nausea-vomiting Low blood pressure Colonic spasm

The data here tabulated is from references 3,4,5,6,7, given below.

When the clinical picture is suggestive of functional disorder, the diagnosis is supported by the presence of the following indications of autonomic lability:

Variable Blood Pressure
Body Temperature Variations
Changing pulse rate
Deviations in B. M. R.
Exaggerated Cold Pressure Reflex
Oculo-Cardiac Reflex Abnormalities
Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relieving the somatic disturbance to prepare the patient for psychotherapy*; 2) guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

*Drug treatment using adrenergic and cholinergic blocking agents in conjunction with sedatives. 8,9,10.

1. Ebaugh, F.: Postgrad. Med. 4: 208, 1948. 2. Wilbur, D.: J.A.M.A. 141: 1199, 1949. 3. Williams, E. and Carmichael, C.: J. Nat'l. Med. Assoc. 42: 32, 1950. 4. Goodman, L. and Gilman, A.: The Pharmacological Basis of Therapeutics, The Macmillan Co., 1941. 5. Katz, L. et al: Ann. Int. Med. 27: 261, 1947. 6. Weiss, E. et al: Am. J. Psychiat. 107: 264, 1950. 7. Alvarez, W.: Chicago Med. Soc. Bulletin, 581, 1950. 8. Rakoff, A.: A Course in Practical Therapeutics, Williams and Wilkins, 1948. 9. Karnosh, L. and Zucker, E.: A Handbook of Psychiatry. C. V. Mosby Co., 1945. 10. Harris, L.: Canad. M.A.J. 58: 251, 1948.

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MEETINGS OF MEDICAL SOCIETIES ANNUAL SOCIETY MEETINGS

American Medical Association.....Atlantic City, June 11-15, 1951	
Oregon State Medical Society.....Portland, Oct. 10-13, 1951	
President, W. J. Weese	Secretary, R. F. Miller
Ontario	Portland
Washington State Medical Association.....Seattle—Sept. 9-12, 1951	
President, K. L. Partlow	Secretary, J. W. Haviland
Olympia	Seattle
Idaho State Medical Association.....Sun Valley—June 17-20, 1951	
President, R. T. Scott	Secretary, R. S. McKean
Lewiston	Boise
Alaska Territorial Medical Association,	
Ketchikan—May 31-June 2, 1951	
President, D. Cramer	Secretary, W. P. Blanton
Ketchikan	Juneau

PERIODICAL SOCIETY MEETINGS

NORTHWEST

North Pacific Society of Neurology and Psychiatry,	
April 20-21, 1951—Victoria, B. C.	
President, C. P. Larson	Secretary, G. B. Haugen
Tacoma	Portland
North Pacific Orthopedic Society.....Sun Valley—May, 1951	
Secretary, J. K. Burton	President, W. H. Goering
Boise	Tacoma
North Pacific Pediatric Society.....Seattle—March 10	
President, Gordon Matthews	Secretary, S. J. Babson
Vancouver, B. C.	Portland
North Pacific Surgical Assn...Vancouver, B. C., Nov. 16-17, 1951	
President, S. F. Herrmann	Secretary, J. A. Duncan
Tacoma	Seattle
Pacific Northwest Society of Pathologists	
April 6-7, Timberline Lodge, Mount Hood	
President, C. P. Larson	Secretary, G. A. C. Snyder
Tacoma	Portland

OREGON

Central Willamette Society.....Second Thursday	
President, W. W. Ball	Secretary, F. R. Asbury
Corvallis	Corvallis
Oregon Academy of Ophthalmology and Otolaryngology—Third	
Tuesday, Old Heathman Hotel, Portland	
President, Max Simons	Secretary, R. S. Fixott
Portland	Portland
Oregon Pathologists Association, Second Wednesday—Portland	
President, V. D. Sneeden	Secretary, J. E. Nohlgren
Portland	Portland
Portland Academy of Pediatrics.....First Monday	
President, S. G. Babson	Secretary, Edward Rector
Portland	Portland
Portland Surgical Society.....Last Tuesday	
President, J. M. Roberts	Secretary, J. W. Nadal
Portland	Portland
Southern Oregon Society.....May, 1951—Klamath Falls	
President, H. B. Currin	Secretary, F. C. Adams
Klamath Falls	Klamath Falls

WASHINGTON

Puget Sound Academy of Ophthalmology and Otolaryngology	
Third Tuesday — Seattle or Tacoma	
President, J. F. Tolan	Secretary, Willard Goff
Seattle	Seattle
Seattle Academy of Internal Medicine.....April 23	
President, J. M. Bowers	Secretary, W. E. Leede
Seattle	Seattle
Seattle Academy of Surgery.....Third Friday	
President, J. C. Bennett	Secretary, D. A. Huckaby
Seattle	Seattle
Seattle Gynecological Society.....Third Wednesday	
President, C. D. Kimball	Secretary, Robert Plant
Seattle	Seattle
Seattle Pediatric Society.....Fourth Friday	
President, W. A. Jaquette	Secretary, G. E. M. Adkins
Seattle	Seattle
Seattle Psychoanalytic Study Group.....First Thursday	
President, Gert Heilbrunn	Secretary, E. W. Haertig
Seattle	Seattle
Seattle Surgical Society.....Second Friday	
President, J. A. Duncan	Secretary, R. B. Hearne
Seattle	Seattle
Spokane Surgical Society.....Annual Meeting April 21, 1951	
President, A. F. Cunningham	Secretary, F. L. Meeske
Spokane	Spokane
Washington State Obstetrical Society.....Seattle—April 7, 1951	
President, C. D. Kimball	Secretary, E. G. Layton
Seattle	Seattle
Washington State Society of Anesthesiologists.....Fourth Friday	
President, D. C. Moore	Secretary, K. F. Eather
Seattle	Seattle



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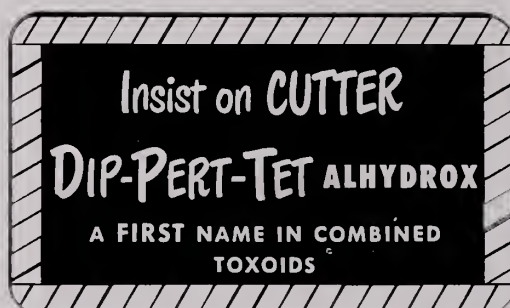


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APRIL, 1951

No. 4

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See Page 250 for first installment of *Medicine's
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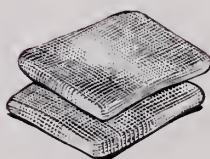
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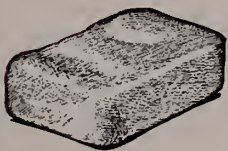


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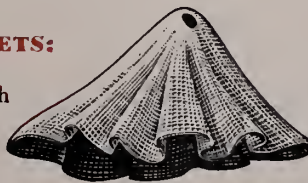
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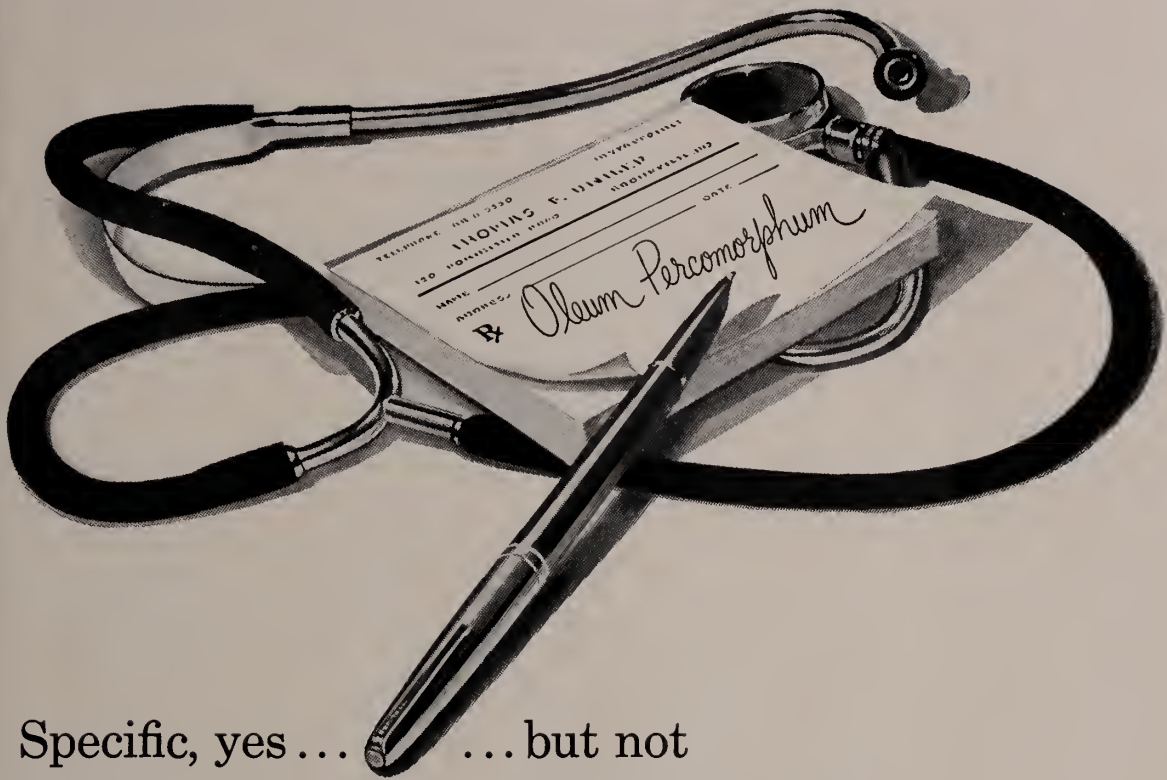
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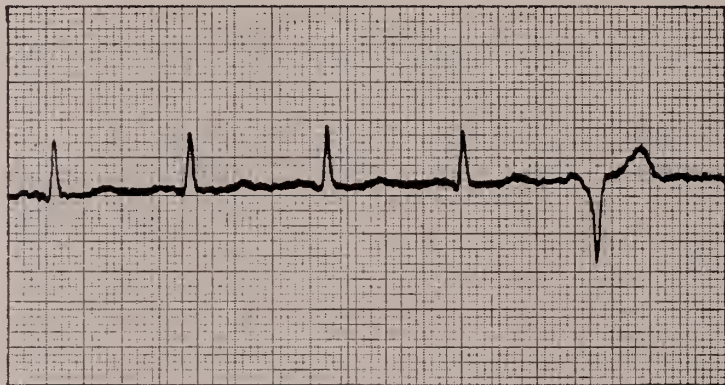
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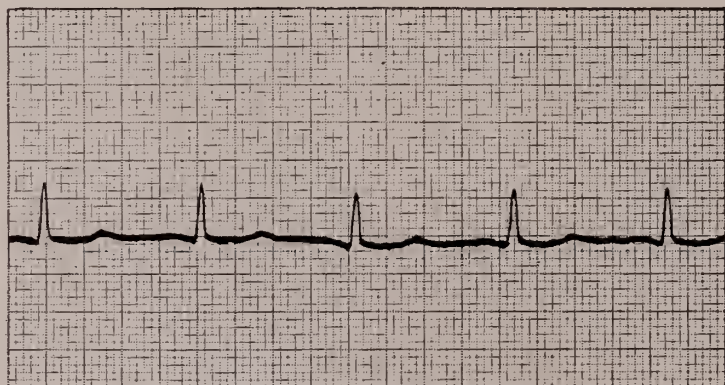
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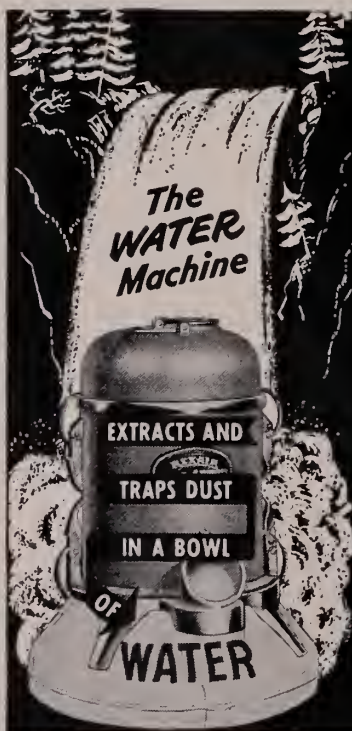
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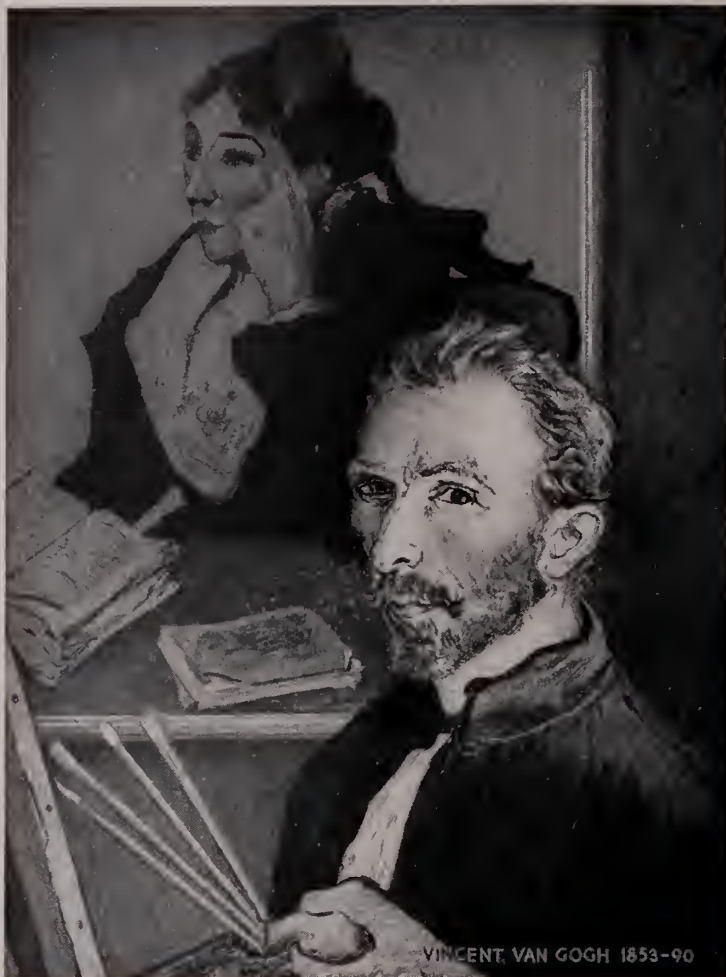


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1. Thewlis, M., and Gale, E. T.: Ambulatory Care of the Aged, Geriatrics, 5:331 (Nov.-Dec.) 1950.

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NORTHWEST MEDICINE

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EDITORIALS

Clarifying an Intricate Topic

In this issue we are pleased to publish the first part of a two-part article dealing with doctor and hospital relations. The concluding part will appear next month.

The preparation of this article was suggested by the editors of NORTHWEST MEDICINE at the time the American Hospital Association announced the hospitals were preparing to operate the hospital standardization program long conducted by the

American College of Surgeons. This announcement focused attention on the relations existing between the medical profession and hospitals, and it was felt a study of the matter might lead to an article of considerable value to doctors.

The result has not been disappointing. "Medicine's Problem Child, the Hospital," is a noteworthy contribution in understanding an intricate subject, and qualifies as required reading.

Santa Claus, M.D.*

W. W. Bauer, director of the Bureau of Health Education of the A. M. A., has written a book on political medicine titled "Santa Claus, M.D." Presented as "Your doctor's criticism of 'socialized' medicine and his own constructive twelve-point program for safeguarding and improving your health," this is quite obviously the latest propaganda for the "party line" of the A. M. A. As such it is a very pleasant surprise. It is readable. It is reasonable. It does not insult the intelligence of the reader.

In form, it is a lecture written in the first person to the individual reader addressed as "you." It is noteworthy in avoiding name-calling, categorical statements and arguments from the abstract. Instead, it depicts in terms of every-day experience, common knowledge and common sense the probable effects of proposed changes in medical practice. It depicts these effects as they will apply to the reader, to his friends and relatives, and to his community. To a large extent, it asks him to draw his own conclusions.

Each principle argument of the socializers is successively refuted, without venom or rancor. Its absurdity is demonstrated. The "real problem" is noted and a reasonable solution is sought. This turns out to be point X of the A. M. A. twelve-point program, so we move on to the next argument. It

is smooth. It is devastating. It is done with superb skill and altogether admirably.

This book should prove convincing to many people. What is more important, it sets a precedent of intellectual respectability and emotional acceptability that could well be followed in all medical polemics and apologetics.

It should be worth any doctor's time to read this book, both for what it says and for how it is said. And he should pass on to his friends and his patients the things he learns.

Despite all this, the book has fundamental weaknesses and deficiencies which should be noted. By and large, these reflect corresponding defects in the A. M. A. party line, and they play directly into the hands of the socializers by accepting the false premises upon which the arguments of the socializers rest.

The most serious shortcoming lies in a false concept of "medical service" or "medical care." This is regarded as something tangible and measurable—almost as having substance—as being, in a sense, a commodity which can be provided or dispensed in recognizable form and in measurable amount to those who need it.

Part and parcel of this absurdity is the concept of something similarly substantial called health—something that people can possess, or can lack in identifiable measure and which doctors can supply. And we even find acceptance of that crowning absurdity, the concept of collective health.

*Santa Claus, M.D. By W. W. Bauer, M.D. 266 pp. \$2.75. The Bobbs-Merrill Company, Inc., New York, 1950.

Conversely we find inadequate recognition of the importance of professional responsibility and freedom and of "personalization" in medicine. "Medical care" designed to adapt the individual to "the needs of society," or to standards set by other persons, may be all right for cattle or for slaves, but not for free men.

The second weakness lies in the assumption that "compulsion is the issue." Compulsion is an issue, and an important one, but far more important and fundamental is the issue of individual versus collective responsibility for the health of the individual.

By accepting collective responsibility as the most desirable arrangement, rather than as a necessary evil to be minimized insofar as possible, both Dr. Bauer and the A. M. A. concede the battle before

they begin to fight. Responsibility and freedom of action are, by their very nature, inseparable.

There can be no such thing as collective-private practice. There can be no real freedom for either the doctor nor the patient under any form of collective practice or payment. Collectivism "the voluntary way" has advantage only insofar as people remain free to withdraw and to resume control of their own destinies whenever the tyranny of collectivism becomes unbearable.

Dr. Bauer has scotched the irresponsible promises of the socializers. He has demolished their superstructure of dishonest representation and specious argument. He has presented the position of the A. M. A. both favorably and convincingly. The basic unsoundness of the A. M. A. position will continue to haunt us.

The Yakima Republic Is Right

The recent proposal of the State Health Department to establish the health department's own bureaus in the counties of the state stirred up a skirmish that indicates the constant alertness that must be observed by the medical profession if it is to successfully combat the trend toward "state" or socialized medicine, or contract doctors.

County and state medical bureaus quickly pointed out the duplication of services that would result from the proposal and were able to effect a compromise by agreeing to service the supplying of eyeglasses, drugs, appliances and private hospitalization for welfare recipients under the new relief law (Initiative 178) for 10 per cent of the dollar volume of the work handled by the bureau.

The Yakima, Wash., *Republic*, in its issue of February 2, 1951, revealed its awareness of the threat in the following editorial, reprinted in part, which we think will be approved and appreciated by medical men everywhere:

MEDICAL REMINDER

A skirmish over a small appropriation for a certain phase of welfare medical care under

Initiative 178 developed at Olympia this week. Its importance to the public was not at all apparent. But in this incident, as with like ones that may arise again before the legislature adjourns there may be a fundamental issue involved. That issue is whether all medical, dental and related services for welfare recipients are to be handled with state-employed doctors and staffs, or whether the medical profession itself shall be permitted to administer the program on contracts with the state and through medical bureaus.

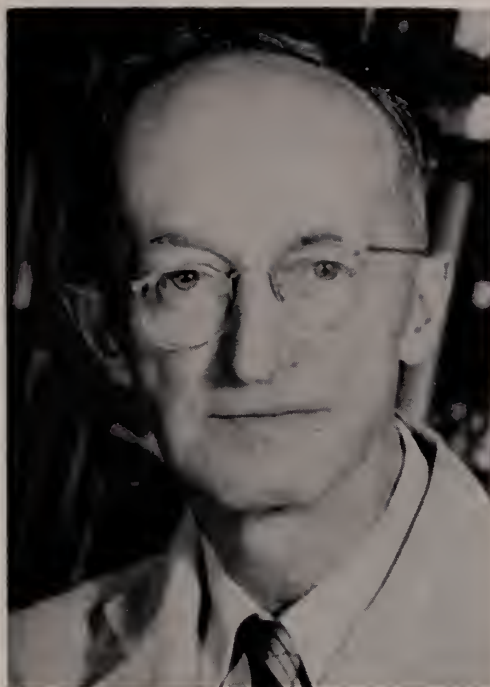
We believe that *wherever possible* these services should be both provided and administered by the doctors themselves. We strongly believe, for example, that such an approach to the problem in Yakima County is many times more efficient and economical than were the state health department to (1) duplicate the medical bureau's administrative organization; (2) establish a state schedule of fees as the primary basis of control, or (3) develop a medical bureaucracy of salaried professional men. Any or all of these courses would not only be wasteful in practice but they would be wrong in principle.



In Memoriam

WILLIAM FITCH ALLEN

A.B., A.M., PH.D., Sc.D. (HON.)



THE untimely death of Dr. William F. Allen at Portland, Oregon, on Sunday, March 11, 1951, removed from the ranks of medical research one of its outstanding scientists. The exact influence on Northwest American medical education and basic scientific research of this great teacher and investigator will probably never be fully appreciated. However, its effect upon the promotion of fundamental research in the University of Oregon Medical School was unmistakably profound and pervasive.

Dr. Allen was born at Oneonta, New York, on November 11, 1875, attended primary and secondary schools at Holland Patent, New York, matriculated in 1896 at Cornell University, where he studied two years, and then came west to Stanford University. Here he came under the influence of Stanford's first president, David Starr Jordan, an outstanding biologist of his time. Dr. Allen frequently referred to and was obviously impressed by the fact that Dr. Jordan, although president of a university, observed regular laboratory hours devoted to his own research. It was during this Stanford interval that Dr. Allen, already interested in biology, began work with a United States Fish Commission Survey in California and Oregon and for a number of years his scientific investigations were largely confined to ichthyology. It was during this period also that he met and formed a lasting friendship with Dr. Anton J. Carlson, who was then in the department of physiology at Stanford. He obtained his Bachelor of Arts degree from Stanford in 1900, his Master's degree in 1902, and his degree of Doctor of Philosophy from Minnesota in 1915. His time between 1901 and 1915 was spent in part on the Stanford Campus and at the Marine Laboratory (1901-1906); at the University of California in physiology (1906-1910); as instructor in embryology and comparative anatomy at the University of Illinois (1910-1911) and in histology, embryology and neurology at the University of Minnesota (1911-1916).

It was while Dr. Allen was at the University of California working with Prof. Jacques Loeb that he met Augusta Nahl, a daughter of the California artist, Arthur C. Nahl. They were married in 1908, two kindred spirits, she an understanding and true helpmate who with their married son, Horace, now survives him.

In 1916, with his wife and young son, this industrious and well trained young scientist, whose interests were now turned to the field of neurological anatomy and physiology, came to the University of Oregon Medical

School as Professor of Anatomy. He retained this post until 1946, when he became emeritus professor, the honorary degree Doctor of Science having been given to him by the University of Oregon in 1945.

The list of Dr. Allen's publications, which includes one unpublished manuscript completed and submitted for publication just three days before his death, numbered fifty-six. All of his work since approximately 1916 was concerned with the anatomy and physiology of the nervous system. During the last ten years he was particularly interested in the experimental study of conditioned responses in dogs and their relationship to cerebral localization. His published work reflected his laboratory experiments—all done with critical, painstaking accuracy. Time and effort meant nothing to this remarkable man, who, in his own quiet, unobtrusive way, was able to attract Dr. Olof Larsell to his staff and inspire the young men in his department with zeal and zest for investigation and scientific honesty. This influence, we must repeat, in a profound and subtle manner inevitably affected the other preclinical departments of the Medical School with similar wholesome effect. In spite of preoccupation with his own investigations he was ever ready to give an attentive ear and a helping hand, scientifically or financially, to all who sought them. Scrupulously honest, he could not restrain expressing his disapproval even under difficult circumstances when he felt that the tenets of scientific integrity had been violated. Small in stature, he was a giant of moral courage and productive, critical, investigative drive.

Dr. Allen's death was caused by an asymptomatic cancer of the pancreas with disseminated metastases, all of which had given him little if any discomfort. Just before entering the hospital for study he had completed and transcribed the results of his last two years of research. He was keenly alert and interested in his work up to the time he discovered that he had a serious affliction. His remark to the writer three days before his death was characteristic of his courage and ability to face any situation calmly, viz., "Well, it seems that the old gray mare has had her last fling." He expressed his real relief and gratification at having been able to complete and send off for publication the results of his last big, investigative effort. His many students, friends and admirers will be comforted to know that the end was dramatically rapid and apparently painless for this great teacher, scientist and above all, real man.

KARL H. MARTZLOFF, M.D.

ORIGINAL ARTICLES

Medicine's Problem Child, The Hospital

T. F. LAYE, M.D.

CHICAGO, ILL.

PART I

MANY physicians are unhappy with the hospitals. If there is any doubt on the point it should be thoroughly removed by the number of resolutions on the subject offered recent A. M. A. House of Delegates meetings, by the frequent wails of radiologists, pathologists and others, and by the report of the Hess committee made after a detailed and lengthy investigation of the practice of medicine by hospitals.

On the other hand, opinions freely expressed by some hospital people would have the wording of the title reversed. Strictly from the viewpoint of these officials in relation to policies or long-range objectives of hospitals it must be admitted some doctors may seem a problem. Or at any rate a stumbling block to be surmounted. This adds unanimity, makes it obvious enough dissatisfaction afflicts a field in which relations ideally should be harmonious that it might be beneficial to appraise some prominent factors involved in the hope this may suggest some course of action to restore a full measure of contentment.

To clarify matters at the outset, two facts should be stressed. Not all hospitals are problems. Chief offenders are usually found in some metropolitan centers or areas of large population, while the degree of the problems decreases somewhat as the distance from heavy population centers increases. And, since problem hospitals did not get that way in the absence of assistance and lapses furnished them by members of the medical profession, the profession must assume a measure of responsibility for creating or permitting conditions of which it now complains as well as for any solution developed.

Stripped of superfluities, the basic differences between doctors and hospitals center upon the role which hospitals should play in the healing picture, the fundamental point being whether the nation's doctors, or hospitals and hospital administrations, shall have responsibility for healing procedures.

The essential, basic ingredient of good medical care, and indeed the fundamental standard against which all medical care can be measured, is the direct, responsible relationship existing between the individual doctor and the individual patient. Physicians have long held theirs is the primary responsibility for rendering good medical care in this rela-

tionship and have insisted on the longest years of preparation to meet it. Physicians are unwilling to relinquish this primary responsibility to any intermediate party, whether individual, hospital or hospital administration, or governmental agency. The result over the years is that Americans have benefited by having the best medical care in the world.

Under this scheme of things, doctors have always considered in the final analysis the hospital is simply another mechanism with which the physician treats his patients. They readily admit it is an important device or aid, one which has peculiar difficulties associated with its maintenance and operation, but one which, in spite of being an important link in the chain of healing procedures, is, nevertheless, a link subordinate to the doctor's responsibility.

Diametrically opposed is the view of many hospitals and hospital administrators. Proponents of this hospital view hold the hospital must be the "focal point of *all* (emphasis mine) medical activity of the community."¹ They contend that the hospital governing board, by virtue of the creation of the hospital, acquires both a legal and a moral right to assume responsibility for the community's health with all that this implies. It is becoming increasingly admitted by many such proponents a logical end result of this includes a medical profession completely "in accord" with hospital needs.

Doctors claim this means a profession completely subservient to hospitals and a condition which would utterly destroy the keystone of good medical care, the direct patient-doctor responsible relationship. Thus it is not in the public interest and they want none of it. So the tension continues.

Onset of difficulties in doctor-hospital relations goes back many years and involves numerous incidents of historical interest not pertinent to this analysis. An exception, however, is the role of hospitals as a major outlet for certain religious and charitable activities continuing from medieval times to the present. This is a persisting background fact which should not be underestimated in any attempt to understand today's situation.

At some risk of oversimplification it appears, for purposes of this analysis, the laying of the ground-

1. "Organization of the Medical Staff of the Hospital," American Hospital Association publication.

work for conflicts in doctor-hospital relations can be dated to the development of asepsis and its application to surgery. In earlier years hospitals were too often pesthouses and the decision to send a patient to a hospital was frequently considered the equivalent of a death sentence. If any surgery was involved the outcome became almost a certainty, due to the prevalence of post-operative infections and complications. Consequently hospitals were regarded with something less than benevolence and surgeons as a class hardly ranked above them, while the family doctor, who came into one's home and performed his healing ministrations there, was the member of the profession held in highest esteem.

With the development of asepsis and its application to surgery, all this changed. Surgery, the ugly duckling of the healing arts, suddenly turned into the beautiful swan, and the surgeon blossomed into quite a fellow. The resulting Great Surgeons—and great operators—aided and abetted by increasing numbers of patients who survived to brag about their scars and stitches, together precipitated the era of the Great Operation which started hospitals on their impressive way.

Glamorizing the Great Operation and persuading surgeons to perform their new-found wonders in hospitals instead of private surgeries was not without cost to the hospitals. To supply the equipment and other facilities necessary, special rooms and services had to be acquired or created and maintained and nursing and other personnel increased, all of which placed a strain on all hospital facilities.

But, to offset increased costs, hospitals were given multiple and overlapping opportunities to meet them. By contributing to increased survivals they were able to establish the best possible kind of goodwill and soon realized this mounting reservoir could be tapped in several ways to their advantage. Patients displayed a willingness to pay more for hospital services and more patients survived to discharge their obligations. The amounts and sources of voluntary and charitable aid which hospitals could attract broadened. It became easier to place on their governing boards a type of prominent citizen who formerly fought shy of the assignment. In turn, this frequently resulted not only in improved management and utilization of finances, but also in hospitals becoming the recipients of increasing numbers of gifts, bequests and endowments for buildings, equipment, research and operating expenses.

Keeping pace with these opportunities, the continuing advance of science resulted in the development of a number of medical specialties in addition to surgery. These proved a further boon to hospitals, for few specialists felt able to do their best work without special facilities and were happy to

use those which alert hospitals made readily available to them. From this came a development with an unexpected turn. In addition to demanding participation in the mysteries and benefits of specialism, patients proved willing, even anxious, to pay exceedingly well for the privilege. From this arose the practice by hospitals, continuing to this day, of charging all the traffic will bear in one phase of hospital activities where funds can be extracted easily, to obtain funds to assist some other phases where high charges necessary to meet costs are difficult for patients to understand, or for other hospital purposes. Lest criticism for this development be directed solely at hospitals, it should be noted in passing that hospitals could not have established or maintained this convenient device without the ignorance, tacit consent or connivance of individual doctors or segments of the medical profession.

The net result of the conditions noted above was to transform many hospitals from their philanthropic concept into formidable financial institutions. Yet, in spite of these changes, for many years the conflicting forces inherent in the doctors-hospitals-public relationship contrived to maintain a degree of balance generally accepted by all concerned, and for the most part conducted in the public interest.

Disturbance of this balance and its replacement by the current uncertain or deteriorating situation may be attributed to several factors but unquestionably the major forces were two in number—the economic depression of the 1930's and the attainment of prominence by a number of socialistic political planners, together with the conditions of continuing instability accompanying their activities. Some may feel that World War II should be listed as a third force, but, while it aggravated or accentuated certain imbalances in the forces operating, it is doubtful there was introduced any factor not previously present.

The Great Depression disrupted hospital finances as it did most finances. Receipts dropped alarmingly and much faster than the curve of utilization. Most hospitals immediately re-examined their costs, curtailed these where possible and increased their charges to patients. But retrenchment and increased charges in themselves proved insufficient as the utilization curve resumed its upward trend and added something new. Where formerly receipts had generally kept pace with utilization, now the increased use of hospitals merely gave them a huge charity or credit problem to aggravate already embarrassed finances. Nor could the hospitals turn, as had long been their custom, to gifts and earnings from endowments to balance extra charity needs and credit losses. Diminished or absent earnings due to the depression, coupled with the high taxes which accompanied the activities of social planning

politicians, effectively dried up old revenue channels and prevented the development of sources of new gifts and endowment funds.

To meet these conditions the hospitals first threw into the breach better administration and career administrators and later developed their Blue Cross organizations.

PART II

Doctors of medicine derive their legal status by following a prescribed course of training and preparation usually covering a total of ten or more years beyond high school, and being granted a license after passing the examinations of an examining board, an agency of the state. This license is based on satisfying a stated minimum of requirements and indicates the holder has met and surmounted the critical scrutiny of the only legal entity authorized to permit him to practice medicine and legally to supervise his professional conduct thereafter.

Hospitals as today constituted have a legal position in their own right, completely independent of any thoughts or wishes the medical profession may have in the matter. The voluntary or non-profit type derive their legal status from a charter granted usually by some agency of the state dealing primarily with corporations, or from a parent sectarian, fraternal or other body. County hospitals and others of similar relationship to governmental units derive their status directly from such units.

The positions given above are basic and must be kept constantly in mind in appraising the relations between doctors and hospitals. Above all it should be clearly understood that in this independent legal status of the respective parties, hospitals have not the slightest jurisdiction over doctors and the practice of medicine. *Until physicians expose themselves* to hospitals in seeking admission for their patients! This key point in the relationship is of the utmost significance. Among other things, it suggests an avenue of hope in untangling the present scrambled situation.

Insofar as hospitals are concerned, the powers obtained by charter may be exercised directly by the fraternal or other order involved, but usually these are exercised by an intermediate governing board enjoying some such designation as board of governors or trustees. Most hospitals following this design have matters so constituted that members of such boards are appointed, and if it is so desired the self-perpetuation of governing boards is not at all difficult to arrange.

While in some instances actual administration of hospitals today remains in the hands of governing boards, the increased utilization of hospitals and the complexity of their management has resulted

To appreciate the full significance of these measures is to have insight into the very heart of the problem today facing the medical profession. For a clear understanding it is also necessary to bear in mind some fundamental aspects of the legal position of doctors and the organization of hospitals which many doctors may not know or may have forgotten.

in the delegation of much authority to the appointees of governing boards. Of recent years such designates have tended more and more to be career administrators, at the same time boards of trustees have become less and less informed in hospital affairs and increasingly dependent upon hospital administrators and the data supplied by them for what information they have. This fact, coupled with the circumstances that doctors are rarely if ever included among the trustees and that many governing boards tend toward self-perpetuation, has given rise among many doctors to the conviction that governing boards in many instances are nothing but the stooges of hospital administrators.

On behalf of the hospital administrators it must be said they were and are confronted with a problem of great complexity and expect to be judged strictly by their success or failure in solving it. Under this compulsion it is not strange they should resort to certain methods demonstrated successful in the more predatory world of business. Having thoroughly analyzed their costs, charging all the traffic will bear down to the last aspirin tablet, having minimized credit losses by demanding advance deposits and boosting their Blue Cross program, it is not surprising they should concern themselves with the remaining major variable in hospital affairs, the services of doctors.

In trying to bring under control this remaining portion of what they consider their problem, the hospitals and their administrators find nothing illogical. They disclaim, and for the most part probably do not have the slightest ill will toward the medical profession. To them it is merely a matter of sound business practice looking toward a better job of administration and many seem actually surprised that the doctors should be the least disturbed by it. This concern shown by doctors is due to the fact they recognize in this a threat to good medical care by impairment of the essential ingredient, the direct responsible patient-doctor relationship, while the administrators apparently do not.

The pattern which lends itself to control of doctors by hospitals has come to the attention of every doctor who has dealt with hospitals, but because much of it is encountered piecemeal it is not always clear how the various pieces dovetail. At present chief devices are found in the selection of hospital

trustees, the staff memberships of doctors, the enforcement of various portions of the hospital standardization program and in patient admissions. There are also increasing indications a flanking type of control may be developing by use of the Blue Cross plans and activities, as will be mentioned later.

According to the literature of the American Hospital Association,² guiding principle in the selection of hospital trustees is that the board should represent a fair cross-section of the community. But in defining what constitutes a fair cross-section the medical profession goes entirely unmentioned. This oversight may not be a studied one but, nevertheless, it is there² and, in view of the definite role allotted doctors elsewhere in the association's literature, this role being *not* on governing boards, one wonders. A doctor may be named to the board's "joint advisory committee" or "medical advisory board," consisting of equal numbers of trustees and medical staff doctors with the administrator ex-officio, but this is strictly an advisory status which any governing board may completely ignore and disregard.

Since hospitals cannot function without doctors, the first and most important duty of the governing boards is to appoint a medical staff. It is a beautiful duty. When exercised with skill and finesse it can produce a satisfactory medical staff for the institution, and supply ample assurance the staff can be kept satisfactory or "in accord" as some hospitals have phrased it. Important device in the arrangement is the pledge demanded of each applicant *in advance of appointment*¹ that the doctor will abide by the rules and regulations of the hospital as they affect him and his membership on the hospital staff.

The importance of this device should not be underestimated. With a few notable exceptions, staff doctors have little or nothing to say about what rules and regulations are made, or about their enforcement. The governing boards have the sole responsibility for making hospital policies and for their enforcement. Staff doctors are usually given the privilege, or luxury, of a medical staff advisory committee, or a liaison committee to the governing board, but the recommendations of such committees are purely advisory. The staff advisory device, however, does have the great advantage to the governing board that it affords many doctors the illusion that staff doctors are formulating hospital policies for the benefit of their patients. Also, there have been a number of occasions where the device has been manipulated to act as a buffer between a governing board and a medical staff inclined to be critical of board actions or promulgations.

Analysis of the medical staff membership as a

device to keep doctors "in accord" with hospital needs would not be complete without reference to two refinements, the division of the medical staff into departments based on specialties or sub-specialties, and the "closed" staff principle. There is much which could be stated about these refinements, but it should be sufficient for clear understanding if two salient facts are noted. Departmentalization, from the hospital administration viewpoint, is but an additional logical step in the process mentioned earlier of having specialists do most of their work in hospitals, while the "closed" staff may be considered a further refinement designed to keep staff doctors contented or at least "in accord" with hospital needs. Major objection of doctors is again that maintenance of this situation, while distinctly beneficial to stabilization of hospital affairs, frequently works a needless hardship on both doctor and patient which is not in the interest of good medical care.

Among other factors which disturb doctors, because of the danger raised to good medical care through impairment of the direct doctor-patient responsible relationship, are a number of regulations or promulgations dealing with the maintenance of standards of medical care in hospitals, including such things as medical records and the holding of staff meetings and conferences. The existence of regulations originally designed to promote and maintain high standards is not *per se* unduly disturbing to doctors, for, when properly conducted, it tends to be in the patients' interest; there is considerable concern, however, with the fact the standards used are fashioned by a group representing only a part of the medical profession, yet applied by the hospitals to all. And there is much more concern over the fact the element of compulsion has been introduced into medical staff relationships by some hospitals through reference to the "standards."

Most doctors at some time or other have witnessed or known of instances where some hospitals have not hesitated to take advantage of technical or unintentional failure to comply with "regulations" to visit disciplinary procedures, including outright dismissal, upon the head of unwitting offenders. Similarly, most doctors can recall instances where regard for regulations attributed to standards conflicted with the best possible medical care to patients. As a result of such things, some doctors have been forced to conclude the much ado about standards displayed by some hospitals, and the recent eagerness to "take over" the standardization program from the American College of Surgeons, may be partly due to regard for the standards, but may also be due to the fact that it could provide a stronger, direct club which might be swung to keep doctors in line with hospital needs. Again it should

2. "The Governing Board of the Hospital," American Hospital Association.

be stated not all hospitals avail themselves of this practice.

The device of patient admissions as a possible control measure over doctors is too well known to need elaboration here. Not all hospitals indulge in patient admission manipulations necessarily as a regular thing, but all doctors know that large producers of hospital revenue usually have no difficulty obtaining beds, while those who use hospitals infre-

quently, or happen to be in the bad graces of hospital administrators or influential members of the medical staff, do have difficulty. Hospitals have denied and will deny that this is done, but too many former admitting clerks have talked and too many doctors have collaborated to run spot checks on hospital admissions for the denials to be taken seriously.

(Concluded in May issue)

Cutaneous Manifestations of Systemic Disease*

ROBERT R. KIERLAND, M.D.**

ROCHESTER, MINN.

IN THIS discourse an attempt will be made to reacquaint all of us with the importance of cutaneous symptoms and signs in the recognition and diagnosis of underlying systemic disease. Unfortunately the subject is too broad to permit detailed reporting of the vast role that the skin plays in health and disease; hence, only a rather cursory survey may be made. Because of the fact that only a few dermatologic entities are solely cutaneous, that is, superficial pyococcic and parasitic infections, contact dermatoses and some malignant and benign new growths, the subject could as easily be systemic manifestations of cutaneous disease as cutaneous manifestations of systemic disease. All of this points to the fact that dermatology is an integral part of all of medicine and does not have a distant unrelated field.

The skin is one of the vital organs of the body and yet it is different from many other organs in that it has multiple functions. The most prominent and obvious is protection from external trauma which may be mechanical, chemical or physical. Other functions, equally important, are control of temperature through an extensive blood and nerve supply, respiration, excretion of metabolites through sweat, sebum and sensation. The skin is permeable and gives a vascular response. Sensation is mediated through nonmedullated and medullated nerves with a great variety of anatomic terminations.

It should be recognized and appreciated that the skin is one of the best, and certainly the most practical, indicator of the immune and allergic state. Because of this fact, the skin is useful in diagnosis of tuberculosis, the deep mycoses and other conditions, it demonstrates the allergen in asthma, vasomotor rhinitis and hay fever, it demonstrates

the protection or lack of it in certain contagious diseases such as smallpox or diphtheria.

The great ability of the skin to react in different ways is illustrated by the acute infectious diseases of the exanthema group. Here are a variety of different contagious systemic diseases which are more often than not diagnosed by inspection of the skin. This group will not be dealt with further but it emphasizes to us the importance of the skin in diagnosis.

Other groups of diseases which produce reflections on the skin lend themselves to a rather arbitrary classification.

PRURITUS

The cutaneous manifestations of systemic disease are frequent in number and vary greatly in type from patient to patient. The skin should be one of the first organs of the body examined in the course of any physical examination. It acts as a mirror reflecting signs of bodily health or disease. The symptom referable to the skin which most frequently brings a patient to the office is pruritus or itching. Pruritus may be localized but is more frequently generalized. Oftentimes it is not accompanied by any specific or nonspecific change in the skin.

When patients, particularly aged patients, complain of itching, search must be made for certain underlying manifestations of systemic disease, such as the lymphoblastoma group of diseases, for example Hodgkin's disease, other malignant disorders, arteriosclerosis, hepatic disease with or without jaundice, uremia, diabetes mellitus and occasionally hyperthyroidism. It goes without saying that the local causes of pruritus should be determined as well by thorough examination of the skin.

PIGMENTARY DISORDERS

A large group of patients have disorders of pigmentation; the first and most prominent of these disorders is Addison's disease. In the cutaneous

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**Section on Dermatology and Syphilology, Mayo Clinic.

picture of Addison's disease, there is an increased deposition of melanin which is usually more pronounced on the exposed surfaces of the body and the flexural surfaces, such as the axillae and the crural folds. The pigmentation also may be found in the buccal membranes. The skin is usually soft and velvety.

An interesting rare condition of the skin is known as "acanthosis nigricans." Two types occur, the benign juvenile and the adult variety. The latter may appear at any age but usually after the second decade and its appearance in an adult is almost pathognomonic of malignant disease in one of the internal organs. The benign juvenile type usually appears shortly before or during puberty and individuals affected have some evidence of endocrine imbalance. Acanthosis nigricans is characterized by the involvement of the flexural surfaces of the body together with verrucous hyperplasia and increased melanin pigmentation. When extension of the process occurs, the same cutaneous signs may be found in the neck, gingival margins, sacrum and extremities.

A disorder of iron pigmentation, hemochromatosis or bronze diabetes is manifest on the skin as a bronzing type of hyperpigmentation and with deposition of melanin as well. But more specifically there is deposition of iron pigments, particularly about the propria of the sweat glands and this may be easily diagnosed on microscopic examination of an excised piece of skin. This type of pigmentation is more diffuse than that of Addison's disease and has more of a slate bluish hue. The hue itself is not diagnostic, however. Ochronosis is a rare disorder of pigmentation; like hemochromatosis, it is also an error of metabolism. This is manifested by the deposition of pigment within the cartilages of the body. In later phases it may be associated with arthritis. The error of metabolism involves homogentisic acid and is associated with alkaptonuria. It has been seen in individuals who for some reason or other have ingested phenol.

In the differential diagnosis of disorders of pigmentation, we should always remember that certain heavy metals, such as arsenic, silver, bismuth and gold, may produce a metallic pigmentation and may closely simulate certain of these other disorders just mentioned. It also should be mentioned that diffuse hyperpigmentation due to increased deposition of melanin may be seen in conjunction with many chronic debilitating diseases, particularly chronic hepatic disease and tuberculosis.

ERRORS OF METABOLISM

There are many and widely diversified errors of metabolism. Many of them have manifestations on the skin which may give certain diagnostic clues to the underlying disease present. The first to be

discussed will be xanthomatosis. Xanthomas of the tuberous type appear usually on the extensor surfaces of the body and are found in the tendon sheaths as well. These frequently overlie the bony prominences about the knees, elbows and shoulder points. The common xanthelasma of the lids may be associated but is not in all cases. The lipid elements of the blood are markedly increased—associated systemically with this increase is atheromatosis. Concomitant angina pectoris and coronary disease frequently accompany atheromatosis. These cardiac and vascular phenomena appear in about 40 per cent of the patients with the tuberous type of xanthoma.

There is a disseminate variety of xanthoma, in which the lesions appear as soft, small, yellow papules on the intertriginous areas of the body, such as the axillae and the antecubital fossa. In this variety the lipid elements of the blood are normal. Another systemic complication of this disease is the infiltration of fatty deposits along the mucous membranes of the mouth. The larynx may become involved and tracheotomy may be required for relief of difficult breathing. Diabetes insipidus is frequently associated with disseminate xanthomatosis. Lesions somewhat similar to the disseminate type of xanthoma may occasionally appear with portal cirrhosis. An eruptive type of xanthoma is seen sometimes in patients who have severe diabetes. With xanthoma associated with diabetes or with portal cirrhosis the lipid values are again markedly elevated. Certain types of xanthoma may appear with other errors of metabolism of lipid material but these are extremely rare and will not be mentioned further.

The patient who has diabetes may present another type of lesion which is rarely seen, the so-called necrobiosis lipoidica diabetorum. This is due to fatty infiltration together with partial necrosis underlying the surface of the skin and is characterized further by soft plaques of varying size, usually situated on the lower extremities in which centrally there is a yellowish hue. Toward the periphery this hue gradually turns into shades of red and blue. This is an extremely indolent lesion and one for which there is no specific treatment.

Other errors of metabolism are seen, particularly those which may involve the endocrine system, such as diseases of the thyroid, both those of hyperactivity and hypoactivity. Myxedema may give a characteristic appearance to the skin. Usually there is a dry, scaly, lusterless skin, the hair becomes sparse and lusterless and the nails become brittle. Another type of localized myxedema appears usually on the lower extremities and is characterized by local edema; the cutaneous surface

overlying the edema has a characteristic "pigskin" type of appearance. This type of localized myxedema is almost invariably found in patients with recurrent exophthalmic thyrotoxicosis and is due to a malfunction of the pituitary-thyroid axis. Hyperthyroidism produces certain changes of the skin. The skin is usually moist, soft and velvety. Certain errors of metabolism, such as amyloidosis and porphyria, have frequent manifestations of the skin but they will not be considered because of their rarity.

THE INFECTIVE GRANULOMAS

The granuloma is an inflammatory type of tumor which is usually on an infectious basis. The granulomas to be considered now are those due to syphilis, tuberculosis and the deep mycoses. It should be remembered that in all three conditions the disease is basically systemic, and the cutaneous lesions are usually metastatic in that they arise from some underlying focus which may be in an internal organ, muscle, bone or lymph node. Syphilis, of course, is a notable example of this type of reaction. The misdiagnosis of syphilis all too commonly is due to failure to suspect the disease and further to failure to take advantage of the serologic facilities offered by our state laboratories. The type of syphilitic lesion present in an individual depends entirely on that individual's immune or allergic response. Usually the cutaneous lesions in the late stages are asymmetrical, few in number or even solitary and have a rather characteristic archiform border, in which healing is present with areas of activity. The resulting scar is thin, superficial and noncontractile.

As with syphilis, tuberculosis of the skin is becoming increasingly uncommon but is still encountered in certain portions of the country. Cutaneous tuberculous lesions are usually secondary to internal tuberculous foci. The skin may become involved by direct extension from the underlying focus, such as in scrofuloderma or through a hematogenous dissemination in which any of the various types of the tuberculids may be manifested. On occasions, however, tuberculosis may be inoculated directly into the skin (the primary or secondary cutaneous tuberculous complex). The cutaneous lesions produced by these three types of inoculations vary greatly in appearance and course. As with the other granulomas, tuberculosis should be suspected whenever there are chronic nodules which may or may not be verrucous together with scarring, chronic unexplained ulceration, fistulae or necrotic papules which on evolution leave small pitted scars about the face, ears, fingers and bony prominences.

The deep mycoses, also uncommon, should be considered in the differential diagnosis of any

chronic granulomatous cutaneous lesion. The deep mycoses are blastomycosis, actinomycosis, coccidioidomycosis, histoplasmosis and torulosis. The cutaneous lesions appear secondary to some underlying mycotic focus. The cutaneous, clinical characteristics frequently are not clear cut but the lesions are usually subcutaneous, acute or chronic inflammatory nodules which sooner or later in their course become ulcerative and have a purulent or serosanguineous discharge. In addition they may be verrucous plaques or nodules which sometimes have a tendency toward central healing or chronic draining fistulous tracts connected to bowel, kidney or other organs.

The important thing in consideration of syphilis, tuberculosis or mycoses is first the suspicion, second the proper evaluation of the lesion and, thirdly, proper examination which should include a tuberculin test, a serologic test for syphilis, culture of the drainage material for mycotic organisms and for *Mycobacterium tuberculosis* and also culture and microscopic examination of the excised material together with inoculation into laboratory animals. Occasionally the organism of deep mycosis may be demonstrated directly in material from the suspected lesion. Material removed is treated with 10 to 20 per cent potassium hydroxide and, when the tissue has cleared, it is examined under the microscope and the mycelial filaments or the spores may be demonstrated.

URTICARIA AND RELATED CONDITIONS

Urticaria, together with its related entities, erythema nodosum and erythema multiforme, are frequently seen affections of the skin which may be associated with systemic disease. These conditions are alike in many ways and frequently evidences of all three may be seen in the same patient. Chronic urticaria may be associated with hyperthyroidism, tuberculosis, the rheumatic states, lymphoblastoma, intestinal parasitism and also with psychogenic tension of a considerable degree but, before diagnosis of a psychogenic type of urticaria is made, the systemic disorders mentioned must first be ruled out. It is also important to remember that drugs of almost any nature, sulfonamides, antibiotics and other chemicals may produce the same types of reaction.

These statements apply equally well to erythema multiforme and erythema nodosum. Erythema nodosum may be part of the syndrome of valley fever of which the chronic granuloma of coccidioidomycosis mentioned previously is a late phase. Erythema multiforme may be part of a serious constitutional symptomatology with chills, fever, general malaise and prostration. Unfortunately, the basic etiologic factors of these conditions may remain undiscovered and the patient may have

recurrences of this condition from time to time.

SARCOIDOSIS

Little is known concerning the cause of sarcoidosis which is a systemic disease with many varied symptoms. The cutaneous lesions may be single or multiple and they vary from a single small discrete papule to large multiple nodules which may be disseminated over the body or which may be fused to form a large plaque. The nodules, particularly in Negroes, may ulcerate. In addition, annular forms may be situated superficially on the skin or may be deep, subcutaneous nodules. Among the systemic manifestations of sarcoidosis are the frequent involvement of the liver, lymph nodes, lungs and frequently also seen is osteofibrocystic disease of the small bones of the hands and feet. The salivary gland may be involved and not infrequently the nervous system. On laboratory examination are found hyperproteinemia and not infrequently monocytosis.

DISEASES OF THE BLOOD AND BLOOD VESSELS

In this group of diseases we might consider first the anemias. The diagnosis of pernicious anemia may be suggested by soft skin which has a faint yellowish hue together with glossitis and later by atrophy of the papillae of the tongue. In other types of anemia, chronic ulceration of the lower extremities is associated and this is seen in sickle-cell anemia, certain types of hemolytic anemia and in Mediterranean anemia. Polycythemia vera should be considered from plethoric congested facies and telangiectasia of the skin. Acneiform eruptions also have been described in patients with polycythemia.

The purpuras may leave their marks on the skin in the forms of petechiae and ecchymoses. These may disappear without sequelae but on the lower extremities they frequently leave stains of hemosiderin. Changes in the bone marrow, the peripheral blood and the spleen must be studied and evaluated in order to determine the type of purpura present. Schonlein's and Henoch's purpura frequently originate in an allergic state and should be investigated and treated from this point of view. It should be remembered that splenectomy may be a lifesaving procedure when the patient has acute thrombocytopenic purpura. It is also important to know that drugs may produce purpuric lesions.

One type of petechial purpura usually is found on the lower extremities but may become generalized. It is not part of any systemic disease as far as is known. This condition seems to be manifestation of increased capillary permeability or fragility. It is characterized by minute petechiae which may produce archiform or annular patterns which may be diffuse or localized. It is not usually a part

of stasis dermatitis but may be. The only sign of which we are aware is that the tourniquet test gives a positive result.

Diseases of the blood vessels or peripheral vascular disease may produce many signs on the skin as, for instance, those produced by Raynaud's disease and Buerger's disease. These conditions are usually diagnosed by the characteristic cutaneous color changes together with the type of ulceration that is present on the phalanges. Stasis dermatitis and venous insufficiency are seen without any systemic component, but may occasionally appear as a result of thrombophlebitis or in association with a large intra-abdominal or retroperitoneal tumor and sometimes during the course of pregnancy. Pregnancy itself produces certain interesting peripheral vascular phenomena in that spider nevi may appear or symmetrical erythema of the palms and soles may be associated.

Ischemic, painful ulcerations usually about the ankles of patients may be seen in the presence of hypertension or arteriosclerosis. This ulcer is small, usually present in small numbers and rarely measures more than 2 cm. in diameter. It is extremely painful and extremely resistant to local treatment.

Chronic cirrhosis of the liver may produce spider nevi which may pulsate and when found may give an indication as to the hepatic disease present. Also, the explanation of recurrent hemorrhages from the nose or stomach may become evident when telangiectatic lesions similar to spider nevi are apparent. Their presence usually serves to confirm the diagnosis of Osler's hereditary familial telangiectasia.

THE COLLAGEN DISEASES

The exact etiologic factor involved in the so-called collagen diseases remains unknown. Yet for the purposes of simplicity the following conditions are classified together: lupus erythematosus, scleroderma and dermatomyositis. Lupus erythematosus may exist in three different types, the acute, the subacute and the chronic. The cutaneous and systemic manifestations of each of these three types vary in degree and severity. Chronic discoid lupus erythematosus carries with it few systemic manifestations. The more prominent symptoms are on the skin which is characterized by an erythematous plaque that is sharply delineated, extends peripherally and may tend to clear centrally with scarring. The characteristic lesion contains telangiectasia, atrophy and erythema and is found most frequently on the exposed areas of the body, the bridge of the nose, the lower lip and the lobes of the ear.

As the condition becomes subacute, the evidences on the skin become more acute as well.

The erythema is more vivid and more pronounced, the areas on the body which are involved are more extensive; there is less apparent atrophy. In the acute phase, erythema is rapidly developing and usually appears over the face, the ears and part of the acra, that is, tips of the fingers and hands. Purpura may be associated. In rare instances the condition becomes bullous. Along with the cutaneous manifestations are severe systemic changes manifested by fatigue, nephritis, prostration, gastro-intestinal upsets, arthralgias and nonbacterial verrucous endocraditis.

Laboratory tests reveal among other conditions pronounced leukopenia, a markedly increased sedimentation rate, nonspecific biologic positive serologic tests for syphilis, hypoproteinemia with reversal of the albumin-globulin ratio and evidence of nephritis with casts, erythrocytes and albuminuria in the urine. An interesting finding is the recently discovered "L.E." cell which may be found in the peripheral blood smear or on sternal biopsy. Photosensitivity is a part of the disease of many patients; frequently lupus erythematosus seems to have its onset or is precipitated by undue exposure to sun. There is also an endocrine influence, particularly in women, the exact nature of which is not understood. Acute lupus erythematosus is seen almost exclusively in women who are of child-bearing age.

Scleroderma is a systemic disease, in which the main findings are on the skin. It is manifested first as thickening and slight edema of the skin which is more prominent on the face and upper extremities, including the fingers and hands. The skin later becomes taut and stiff and difficulty in moving the joints results. The skin then becomes firm and bound to the underlying structures so that the fingers become tapered and glossy and contracture deformity develops. There is pinching of the facies with loss of substance about the nose and about the mouth. A peculiar hyperpigmentation due to increased deposition of melanin is seen about the upper part of the chest and upper extremities in particular.

As the condition progresses in severity and extent of involvement, the periodontal membrane widens characteristically and this change may be seen on the dental roentgenogram. Involvement of the esophagus appears with clinical dysphagia, loss of peristalsis as revealed by roentgenogram and more infrequently the development of a hiatal hernia due to shortening of the esophagus. The gastro-intestinal system may be involved as well and sometimes there are feathery, pulmonary infiltrations as revealed on the roentgenogram of the thorax. In women a particular variety of scleroderma is seen known as acrosclerosis. This carries

a better prognosis than does the generalized, diffuse variety of scleroderma and is associated with Raynaud's phenomena. This latter condition involves primarily the fingers, hands, forearms, face and neck and upper part of the chest.

Dermatomyositis is a rare condition of an unknown cause; it is manifested by myositis involving muscle groups especially about the pelvic and shoulder girdle. The cutaneous manifestations are somewhat similar to those of the dissiminate variety of lupus erythematosus and they consist of telangiectasia and erythema of a peculiar lavender hue known as "heliotrope" which is seen particularly about the eyelids. Sometimes in late phases atrophy of the skin occurs with hyperpigmentation. The myocardium may be involved and also other muscle groups, particularly those of deglutition so that swallowing is difficult.

NEW GROWTHS INCLUDING MALIGNANT CONDITIONS

Among the most prominent of the various malignant conditions of the skin are the lymphoblastomas, including mycosis fungoides, Hodgkin's disease, the leukemias and lymphosarcoma. The cutaneous manifestations vary greatly and may extend all the way from simple generalized pruritus without cutaneous manifestations through urticaria and erythema multiforme-like eruptions up to and including universal exfoliative dermatitis. Most of the manifestations on the skin are nonspecific in that biopsy reveals nondiagnosable changes. However, a diagnosis of lymphoblastoma may be made on the skin by demonstration of the characteristic architecture of the lymphoblastoma. This is particularly true in cases of leukemia and mycosis fungoides. The characteristic architecture of Hodgkin's disease is found infrequently but when present its diagnosis may be made without resorting to biopsy of lymph nodes. The specific cutaneous evidences of lymphoblastoma are usually multiple, discrete or fused subcutaneous nodules which gradually enlarge. Because of the pressure of the underlying infiltration the skin loses its viability and because of loss of vascular supply becomes necrotic and ulceration results.

Another important group are the metastasizing lesions of the internal carcinoma or other types of malignancy. It is surprising how often the first evidence of cutaneous metastasis may appear on the scalp. The lesions may be single or multiple, are frequently flesh colored with slight hues of erythema, but sooner or later if they enlarge they ulcerate. Again, diagnosis of an underlying malignancy may be made by microscopic examination of excised tissue of the skin without resorting to laparotomy.

Epiloia is a condition which has systemic reflections and also cutaneous manifestations in the

form of adenoma sebaceum sometimes associated with neurofibromatosis or von Recklinghausen's disease but is characterized more fully by the presence of retinal tumors, tuberosus sclerosis, convulsions and mental retardation.

MISCELLANEOUS CONDITIONS

A large group of miscellaneous conditions which are truly systemic have their main manifestations and symptoms in the skin. Among these is psoriasis. The cutaneous evidences and the characteristics of psoriasis are well known but hyperuricemia, particularly in the male, is a common association and in certain instances a severe degree of rheumatoid arthritis may appear. Chronic ulcerative colitis may be associated with a peculiar liquefying superficial gangrene of the skin. Even the commonly seen acne vulgaris carries with it the implications of an endocrine disorder or an endocrine imbalance with

emphasis on androgenic activity. Cushing's disease presents an acneiform eruption, obesity, striae distensae and a plethoric facies.

Infarctive types of superficial ulceration of the skin may be found in periarteritis nodosa. Acute, tender, inflammatory nodules along the course of vessels and urticaria frequently are noted.

SUMMARY

An attempt has been made to emphasize the importance of the skin in the diagnosis of systemic conditions. Only a few cutaneous conditions are not part of a systemic disease or do not have some systemic reflection. It is urged that in the course of all physical examinations, particular attention be paid to the skin in order that cutaneous manifestations of disease may be found and advantage taken of the important help offered by the skin in the diagnosis of underlying disease.

Medical Usage of Red Blood Cells*

BERNARD P. HARPOLE, M.D.

PORTLAND, ORE.

DURING World War II over 25,000 units of red cells, left over after removal of plasma in the Armed Services and Red Cross plasma program were used¹ out of several million units for which no use was found. Interest in red cells decreased after the war, especially when the production and use of plasma slackened off because of the fear of homologous serum jaundice.

It has been suggested that ultraviolet irradiation of plasma would decrease the incidence of serum jaundice but recent reports make the value of this process questionable.² Much plasma, however, is still needed to prepare derivatives such as albumin, immune globulin, etc. The armed services have recently requested the blood centers to supply whole blood for plasma processing. This program is not to interfere in any way with the presently existing civilian blood program. These programs will make available considerable quantities of concentrated red cells, the value of which has not been generally appreciated.

After the whole blood is centrifuged and the plasma drawn off there remains about 250 cc. of packed red cells. These cells, if collected in citrate,

are useful for five to seven days, and collected in A. C. D. solution, they outdate in twenty-one days.³ They can be transported, stored and used either concentrated or diluted immediately before administration with saline, glucose or both. They will run as freely as whole blood, through filters, tubing and needles. The reaction rate of patients receiving them is about half that to whole blood.⁴ Reactions, when they do occur, are usually milder than to whole blood.⁵ The patient receiving concentrated cells gets a hemoglobin increase or increase in oxygen carrying capacity equal to 500 cc. of whole blood with an increase of circulating blood volume of only 250 cc.

About 50 per cent of patients on whom whole blood is now being used for transfusions would be benefited just as much or more by an equal volume of packed cells.⁶ Increased use of cells would make more plasma and derivatives available through Red Cross at no cost to the patient. With the rapidly mounting demands from the Armed Services for plasma, the cells from this program will be wasted if they are not used as packed cells.

USES

1. BLOOD LOSS in anemias, due to acute or chronic

*Read before the Seventy-sixth Annual Meeting of Oregon State Medical Society, Gearhart, Oregon, September 27-30, 1950.

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2. Rosenthal, N., Bassan, F. A., and Michael, Sidney R., Probable Transmission of Viral Hepatitis by Ultra-Violet-Irradiated Plasma, J.A.M.A. 144:224-226, Sept. 16, 1950.

3. Barnett, R. N., Fox, R. A., and Shavely, J. G., Hepatitis Following the Use of Irradiated Plasma, J.A.M.A. 144:226-228, Sept. 16, 1950.

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4. Binder, M. L., and Klein, A., Concentrated Red Cell Transfusions, Am. J. M. Sc. 208:95-105, July, 1944.

5. Alt, H. L., Taylor, S. G., III, Curtis, D. L., and Bernard, F. D., Red Cell Transfusions in Treatment of Anemia; Further Observations, Surg., Gynec. & Obst. 78:191-194, Feb., 1944.

6. Falkenstein, A. P., Use of Red Cells in Transfusion Therapy, Surg., Gynec. & Obst., 80:187-189, Feb., 1945.

blood loss, after shock is corrected, can have the level of cells increased rapidly with less danger of overloading the circulation and causing the bleeding to recur.

2. SECONDARY ANEMIAS, refractory to treatment with iron and liver, can be corrected rapidly and, as the transfused cells break down, they serve as material for formation of new cells.⁷

3. BLOOD DYSCRASIAS can be treated with concentrated cells with more economy and less danger of reaction. Because of the small volume of the cells alone, we are able to return the hemoglobin level to normal more rapidly.

4. IN CARDIACS AND CHILDREN with anemias there is smaller volume of concentrated cells and a smaller increment to the total circulating volume. Use of this preparation is, therefore, less apt to produce congestive failure than whole blood.

5. C. O. POISONING can be specifically treated with concentrated cells. The O₂ carrying capacity of the patient's cells is embarrassed by the uptake of CO in preference to O₂. The O₂ carrying capacity can be rapidly improved by the transfusion of packed cells which are needed in these cases much more than is whole blood.

Transfusions of packed cells are done in exactly the same manner as they are with whole blood. The cells are delivered in units consisting of half-filled 500 cc. bottles with a pilot tube. They are available in all types. The patient must be typed and cross-matched. When several units are to be used at one time, they should all be of the same type and intercross matched. The disposable tubing and filter are used the same as for whole blood and the rate of flow is the same.

One would think, with the plasma and anticoagulant solution removed, the sludge of packed cells would be difficult to administer. We have demonstrated, however, that even outdated cells, as well as fresh cells, will flow just as readily as whole blood through any transfusion equipment. No farther diluting is necessary.

In determining rate of flow of this preparation, we found that it flows quite readily through an 18-gauge needle. However, using the thin-walled collapsible plastic disposable tubing, elevation of the bottle more than three feet above the recipient's arm causes the upper portion of the tubing to collapse, thereby losing the further hydrostatic effect of a column of blood more than three feet high. After the upper portion of the tubing begins to collapse, further elevation does not produce any increase in the rate of flow. Any increase in the rate of flow above this can only be achieved by using a larger gauge needle or applying pressure with

the attendant risk of air embolus. This is also true of whole blood.

DOSAGE

An easy way to arrive at the number of units of packed cells required to bring the patient's hemoglobin to the desired level is this:

Formula for determining dosage of whole blood or packed cells:

Eight per cent of body weight in pounds equals blood volume in pints.

Blood volume (desired hemo. per cent minus present hemo. per cent) equals number of units of whole blood or packed cells required.

Let us suppose we have a patient weighing normally 125 pounds with a hemoglobin of 50 per cent that we wish to bring up to 80 per cent.

Eight per cent of 125 equals 10 (pints blood volume) Ten (.80 minus .50) equals 3 units of packed cells required.

This formula will not allow us to anticipate exactly the rise in hemo. we will get but it is valuable as a rule of thumb in estimating the needs of cardiacs, small children and patients in whom bleeding has recently stopped, to avoid overloading the circulation with more fluid than is actually needed.

CASE REPORTS

A. N.—Six-month, nine-pound female, fibrocystic disease pancreas.

February 21. Given 200 cc. cells with an increase of hemo. from 6.7 to 12.7 gm.

March 1. Given 250 cc. whole blood with an increase of hemo. from 12.2 to 14.7 gm.

Both tolerated well—no reaction, but remarkably greater increase in hemo. with the same volume of packed cells. Rt. splenectomy done; patient recovered.

C. R., 5-year-old female; hemolytic anemia congenital. Hemo, 9.52 gm.; increased to 12.28 gm. with 1 unit packed cells. On discharge, spleen had decreased in size and the patient was considerably improved.

I. D., 91-year-old female; aplastic anemia due to lymphosarcomatosis. Given 4 units of packed red cells from 4 pints of blood in a period of 58 minutes. Blood samples taken immediately before and 5 minutes after:

	Before	5 min. After	1 wk. After	1 mo. After
RBC	3.16	4.71	5.06	4.52
Hemo. per cent	60.0%	95.0%	101.0%	93.0%
Hemo. gms.	8.28	13.11	13.94	12.83
Hematocrit	29.2%	45.4%	46.0%	44.0%
WBC	13,900	13,500	12,900	9,500

There was no change in pulse, blood pressure, respiration or temperature during or following this infusion, even though 1000 cc. of packed cells was administered at an average rate of 17 cc. per minute.

SUMMARY

1. Packed red cells are readily available from any blood bank that separates plasma. They may be used without further processing. In banks set up only for plasma or derivative processing, they are a useful byproduct which should not be wasted.

2. Packed red cells increase the hemoglobin and oxygen carrying capacity of the blood with only one-half the increase in total volume produced by whole blood. Because of this they are particularly well suited to the treatment of primary or sec-

7. Muether, R. O., Concentrated Red Blood Cells: Preparation and Use, *South. M. J.* 38:330-334, May, 1945.

ondary anemias, blood dyscrasias, cardiacs, children and CO poisoning.

3. A method of administration of this prepara-

tion is presented, along with a simple formula for estimating dosage requirement of packed cells or whole blood.

Medical Aspects of Atomic Warfare*

RUSSELL H. KAUFMAN, M.D.; JOSEPH M. ROBERTS, M.D.; HAROLD M. ERICKSON, M.D.
PORTLAND, ORE.

LIVING with atom bomb attack hanging over our heads may not be pleasant, but it can be done. The best way to do it is to have a reasonable understanding of the bomb's true dangers and of the steps necessary to minimize them. Atom splitting is just another way of causing an explosion and an atom bomb is merely a collection of elements necessary to produce this result.

POWER OF THE BOMB

An atom bomb of the type used in the Japanese bombings is considered as roughly equivalent to setting off 20,000 tons of T.N.T. at a height of about 2,000 feet above the earth on a clear day. This is the altitude at which a bomb of this power

is estimated to have the greatest effect. Higher than this its blast effect is weakened; lower than this the circle of damage is reduced. The Hiroshima and Nagasaki bombs caused total destruction to buildings and people for one-half mile from the point directly below where the bomb was set off, severe damage for the next half mile and moderate and light damage for the next mile. This is indicated diagrammatically in fig. 1. Casualties requiring medical services come almost entirely from the two outer zones. Don't be misled by loose talk of imaginary weapons a hundred or thousand times as powerful. Certainly more powerful bombs would cause a wider area of damage, but their construction would require increases in explosive force so great as to make them impractical. For example, it would be necessary to double the power of a bomb in order

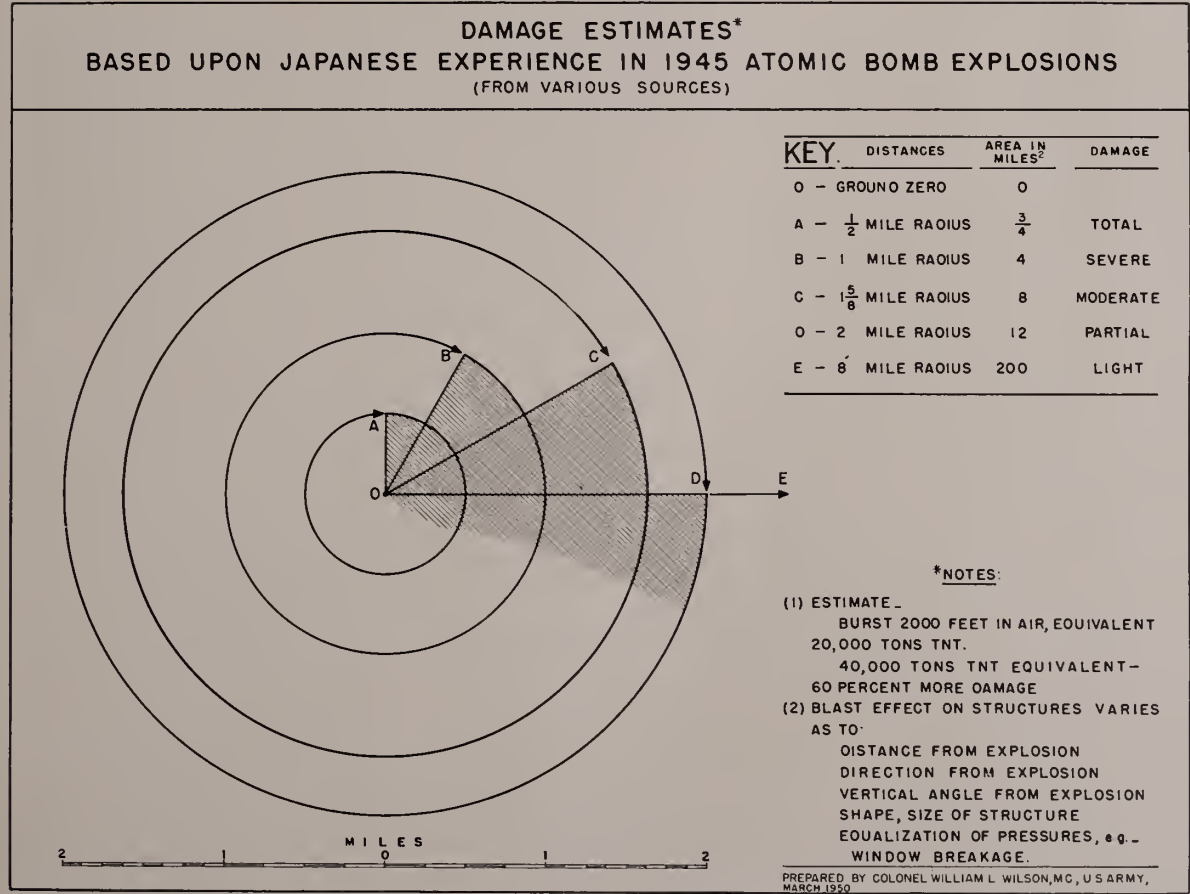


Fig. 1

PER CENT OF
CASUALTIES

WHAT HAPPENS

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1. **Positive Phase
Push Out**

Pressure out from burst.
Usually not enough to kill.
Flying debris caused almost all injuries.

2. **Negative Phase
Suck In**

High winds up to 800 mph.
Blows toward center of burst and up into cloud.

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85

1. **"Flash" Heat**

Flash at time of burst. Burns occur out to two miles. Easily protected by light clothes or any shielding substance.

2. **Secondary Fires**

Started by stoves, short circuits, and the like.
Cut off utilities. Prevent these fires.

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15

1. **"Flash"
Radiation
Gamma
Neutron**

Cannot see, hear, or feel it, but it is there for a flash. Gamma rays are most penetrating and longest range. More material between you and the blast protects you more. Gamma decreases as the square of the distance from the burst.

2. **Lingering
Radiation
Alpha
Beta**

So small it is not a hazard. Disregard it.

Fig. 2

to increase the radius of severe damage and injury by one-fourth or from two to two and a half miles.

WHAT HAPPENS WHEN ATOMIC FISSION OCCURS?

When atomic fission occurs it is accompanied by a terrific blast, release of heat and release of radiant energy. (fig. 2.)

BLAST EFFECT

Blast effect accounts for 65 per cent of casualties and embodies a tremendous positive pressure wave (push out) which spreads radially from the center. Associated with this phase is an intense wind with a velocity of 800 miles per hour at the center blowing in the direction of the blast. This is followed by a negative pressure wave in a large area surrounding the explosion, causing a violent inrushing of wind in direction opposite to the blast wave (suck in). Thus a great quantity of material and debris will be hurled toward the center. An individual fortunate enough to escape the original blast because of shielding might well become a casualty a few seconds later during this second phase.

HEAT EFFECT

At the instant of detonation, temperatures are generated approaching those of the center of the sun and a ball of fire is produced which rapidly spreads from the diameter of the bomb to about 900 feet. It then rises in its own thermal updraft, gradually losing its brilliance and heat in the atomic cloud. Almost any substance within the

area of the ball of fire is burned completely. Flash heat occurs at the time of the burst. It produces burns due to radiant heat (infra red, visible light and ultra-violet light) rather than to hot gasses, as in the case of shell bursts or other explosions. It is easily deflected by light-colored clothing or any shielding substance. Thermal burns result from secondary fires started by stoves, short circuits and the like. Cutting off of utilities may prevent many of these fires. Burns constitute 85 per cent of all casualties.

RADIATION EFFECT

Radiation, in spite of popular ballyhoo, is responsible for only 15 per cent of the casualties. Flash radiation can't be seen, heard, or felt, but is there for a flash. Heavy sections of concrete give maximum protection but it should be emphasized that just plain earth is almost as good—six feet of earth will stop almost all radiation. Lingering radiation is so small that it is not a hazard and may be disregarded; perhaps only 1 per cent of all casualties would be due to delayed radiation.

HOW MANY CASUALTIES SHALL WE PREPARE FOR?

Estimates based on the type of bomb dropped over Japan may be used as a rough basis for medical planning. Casualty rate is directly proportional to the population density (fig. 3). If one atom bomb were detonated in the air over a metropolitan American city at the height intended to produce

	Effort and Results			
	Hiroshimo	Nogasaki	Tokyo	Average 93 Urban Attacks
Planes	1	1	279	173
Bomb Load	1 atomic bomb	1 atomic bomb	1,667 tons	1,129 tons
Population density per square mile	35,000	65,000	130,000	?
Square Miles Destroyed	4.7	1.8	15.8	1.8
Killed and Missing	70- 80,000	35- 40,000	83,600	1,850
Injured	70,000	40,000	102,000	1,830
Casualty rate per square mile	32,000	43,000	11,000	2,000

Fig. 3

maximum physical destruction and assuming that it would produce 120,000 casualties (killed, missing, injured) then there would be 60,000 deaths; 40,000 on the first day and 20,000 after the first day. After the first day the number of deaths halves itself each week for six weeks. Forty thousand hospital beds will be required the first week, 20,000 the second, 17,500 the third and so on. (fig. 4.) Approximately 85 per cent of casualties are burns or mechanical injuries or a combination of both. Ionizing radiation results in only 15 per cent casualties. Most deaths from mechanical injuries occur the first day. Burn cases dominate the problem the first week. Radiation sickness may present a problem in the third and fourth weeks.

TREATMENT OF CASUALTIES

To provide effective care, standardization is essential. Duties of any physician or surgeon will be much the same following an atomic explosion whether he is working in a large or small, highly specialized group. His primary obligation will be to administer first-aid but soon after the immediate emergency his attention will be directed toward the segregation of the wounded so that injured requiring emergency surgery will receive priority of treatment over those with minor injuries. Later his duty will be to direct or perform the definitive care. A plan of casualty sorting is herewith submitted which is

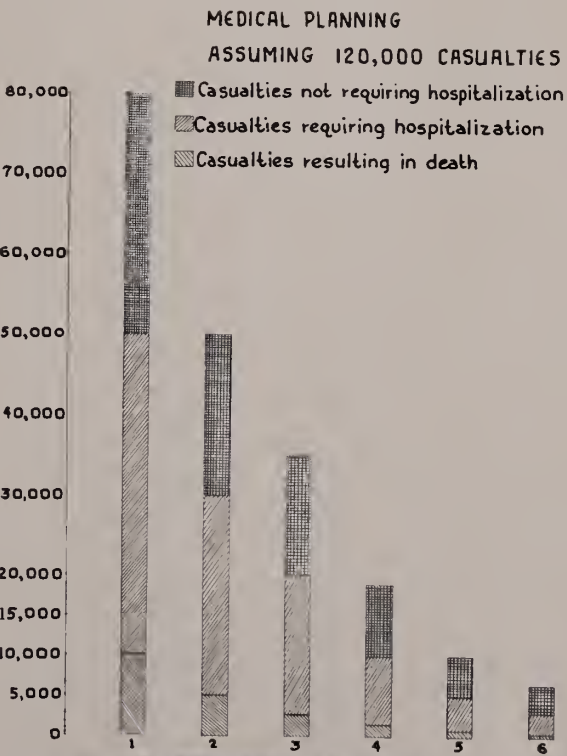


Fig. 4

Chart 4

based upon that used by the most modern military groups.

All injured are sorted into five categories of priority for treatment. This plan of triage is based upon the knowledge that patients with certain types of injuries will only survive a short period of time unless treatment is initiated early. Others suffering from minor bruises or lacerations can very well wait for care with no ill effects caused by delay in treatment.

CLASSIFICATION OF CASUALTIES

Priority I. Patients suffering from penetrating wounds of the chest or abdomen, or from massive hemorrhage, or those with partial avulsion of extremities should receive the highest priority of treatment.

Priority II. Second highest priority is given to those individuals with compound fractures or penetrating wounds of joints.

Priority III. Burn patients or those with crushing injuries comprise a separate category which is unique in that very little surgical care is necessary but shock management is the primary obligation.

Priority IV. Injuries involving peripheral nerves or the brain or the central nervous system frequently require only preliminary shock or splinting care and can then be evacuated to distant specialty centers for definitive care.

Priority V. In any emergency or disaster of any size it will be necessary to delegate less experienced medical personnel or first-aid civilian teams to care for the simple lacerations, fractures, or contusions.

Along with this plan must be evolved a method to tag or designate the injured groups so that evacuation and care can proceed with a minimum of confusion.

BURNS

Most of the energy liberated by atomic bomb explosion is in the form of infra-red radiation, visible light and ultra-violet light. Absorption of such large amounts of radiant energy in a short period of time results in an enormous number of flash burns. Of the Japanese burn casualties 95 per cent were of this type within a radius of four miles from the bomb center. These burns are sharply bordered and have prominent shadow effects. Designs of prints on garments worn are stenciled on the skin by the radiant energy. Such tattoo effects are due to absorption and reflection properties of dark and light clothing. Skin over the hands and face is the most commonly involved area. At the time of experimental bombings in New Mexico, individuals 10 miles from the explosion stated that they felt an intense heat wave momentarily on exposed parts of the body. Flash burns range in depth, as do conventional flame burns, from simple erythema to painless third-degree burn.

TREATMENT OF BURNS

Although no uniform plan of burn treatment has yet been offered, there is almost universal agreement among American surgeons that use of closed pressure dressing infrequently changed is the method of choice. No extensive cleansing of the burned area with soap and water or detergents should be performed unless this can be accomplished under ideal conditions which is unlikely. Only the loose clothing, burned edges of the skin and debris should be removed prior to application of a layer of gauze soaked in sterile vaseline or anhydrous lanolin upon the injured area. Over this covering a second one of gauze, cotton or absorbent material with an outer muslin dressing should be applied with even pressure. Emphasis should be placed on teaching all surgeons and civilians that these dressings should be infrequently changed unless there is evidence of spreading infection under the dressing. When this type of pressure dressing is properly applied very little morphine is required for relief of pain. Barbitol may be used to allay apprehension. The maximum area of body surface in any one flash should be less than 50 per cent. Since shock rarely occurs in patients suffering a 20 per cent or less body surface burn, plasma or blood transfusions will not be required unless the burned area exceeds this 20 per cent extent. These agents should be reserved for patients with more extensive burned areas. Shock is seldom serious in those patients who maintain a continuous adequate urinary output. An hourly recording of urinary secretion on the tags of burned patients will aid the surgeon in differentiating those patients doing well from those developing shock. Hemoglobin and hematocrit determinations will not be available as aids to the surgeon because of the enormous number of burn casualties. Urinary secretion determinations may be the only available source of information. Penicillin and aureomycin are the most effective antibiotic agents to date for the prevention of infection in burn casualties.

It will not be economically sound for all large cities in target areas of the United States to stock pile enormous quantities of dressings, morphine, plasma, and antibiotics to care for the emergency. Therefore, it will be essential for each area to have depots available to other areas and this entire plan of burn management must of necessity be arranged on a mobile personnel and supply basis. A sterile roller type of pressure dressing similar to a giant band-aid which has incorporated within it a fine cotton gauze layer, a central absorptive material and an outer muslin covering is being developed and tested at this time. When this is available it can be cut at any desired length, placed over the burn and held in position by roller bandage or adhesive tape.

BLAST AND TRAUMA EFFECT

Flying glass is the most common cause of lacerated wounds. In some cases in Japan glass fragments were removed which had penetrated over an inch beneath the skin. Similarity of traumatic and blast effects of this explosion to those of other high explosives is such common knowledge that no discussion is necessary.

OPHTHALMIC EFFECTS

No evidence has been reported of permanent eye damage, even to those in Japan who looked directly toward the blast. Temporary dazzling was noted and conjunctivitis from smoke and dust was common. Hemorrhage of the eye developed later from general systemic effects of nuclear radiation. Although temporary blindness resulted when the intense light bleached out the visual purple and persisted for several hours, the effects of visible light are probably not significant.

NUCLEAR RADIATION EFFECT

Ionizing radiation is not detected by the senses but in most persons exposed to it produces shock, nausea, vomiting, fever, diarrhea and later hemorrhage. Those exposed to heavy doses become ill earlier and may die within a week after exposure. Those with minimal exposure have fewer symptoms and generally recover.

Little of a specific nature can be done for the treatment of severe radiation sickness. Whole blood transfusions are required until the bone marrow has had time to regenerate. Amount of blood required is determined by lymphocyte and erythrocyte counts. These counts decrease for five or six days. If the total number of white blood cells falls much below 2,000 prognosis is guarded. White blood cell count is at the present time considered to be the most valuable and direct single index of prognosis of radiation sickness. Patients exposed should have complete rest, avoidance of chills and fatigue, adequate nourishment. Infection should be prevented or controlled by penicillin or aureomycin. Drugs known to effect the bleeding tendency favorably in experimental animals are of questionable therapeutic value at the present time.

CIVIL DEFENSE PLANNING

At Hiroshima and Nagasaki people were totally unprepared. Chaos resulted. Treatment was inadequate. Thousands of lives were lost that could have been saved through good organization. Failure of the Japanese people to prepare for this can be understood because they did not know of the existence of an atomic bomb or what to expect. We do know. We know that as many as 50,000 casualties may be in need of hospitalization. It is estimated that 200 freight cars of medical supplies and 2,500,000 pints of whole blood would be required the first

week after such a disaster. Never before have we been faced with such a problem. Obviously to meet these needs we must have the most careful planning, we must have a well-thought-out organization and we must have nationwide cooperation. It has been made very clear by the military that we cannot depend on the armed forces to do this job for us. Their business is to take care of the enemy. The American Red Cross, although it has a real contribution to make, cannot do the job. Civil government, then, must assume the responsibility. The government cannot do the job alone. It is too enormous. Help of every civilian will be needed. The government can, however, give leadership in planning, organizing and carrying out the program. Some persons have questioned the need for Civil Defense Organization. Until such time as some international organization has actually controlled the use of known weapons of destruction, it would be folly not to organize and plan for disasters.

The national government has been rather slow in developing a program, largely because of complexity of the problem. In 1948 the Department of Defense, after considerable study, issued the much discussed Hopley report. In spite of criticism, the principles outlined in this report are excellent. Shortly thereafter, the National Security Resources Board was established. This board has published much valuable data on atomic bombing and has sponsored courses in Medical Aspects of Atomic Warfare and Radiological Monitoring. It has posed problems resulting from the mock atomic bombing of Washington, D. C., Seattle, Washington, and Chicago, Illinois. Critiques were conducted on the way the civil defense organizations in these cities handled the theoretical war emergency. Incorporating the results of experience gained thereby, the board issued a publication entitled "United States Civil Defense." In addition to recommending a basic national civil defense law, this board recommended establishment of a Civil Defense Administration and appointment of an administrator. This recommendation has now been carried out.

The State of Oregon has progressed farther than most states in civil defense planning. Shortly after the Vanport disaster a group of persons, with J. Guy Strohm, Leland Carey and Harold Erickson represented, met and discussed needs. They drew up bills to establish a civil defense organization in Oregon. These were adopted by the legislature in early 1949 although a request for funds to implement the organization was turned down. In spite of this the Governor appointed the Advisory Council and the administrator and the organization was established (See fig. 5.) This civil defense organization has been active. A great deal has been accomplished. Recently when need became apparent, the State

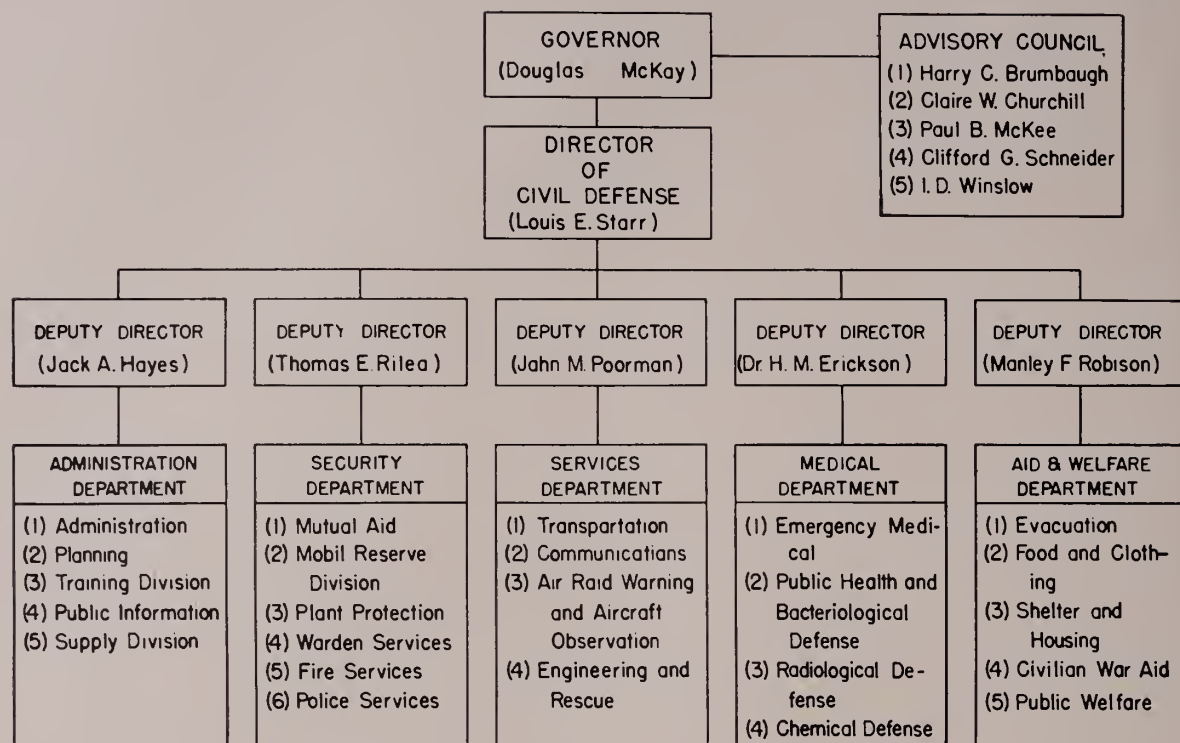


Fig. 5

Emergency Board appropriated \$25,000 to strengthen the program. Budgets have been prepared for consideration of the Governor and the State Legislature to continue and further strengthen this program. Every division is active. Counties and cities have been called on to establish similar organizations. Over-all plans have been developed.

PRINCIPLES OF OPERATION

Utilize existing agencies and relationships. We know that the same agency that does a job daily can best direct and do a job in an emergency. As an example, in planning for the recruitment of physicians and surgeons, we know that the Oregon State Medical Society and local medical societies are the established organizations of physicians and surgeons. These existing organizations are being depended on to mobilize physicians.

Inventory all existing resources and know what additional resources might be made available in an emergency.

Make certain that adequate communications and transportation are available.

Self-help and Mutual Aid. Individuals and communities can do a great deal to help themselves. If a disaster is too great for them to handle, help should be called for, first from neighboring communities with which they have mutual aid agreements and then from the state.

MEDICAL DEPARTMENT

Keeping these principles in mind, the Medical Department of the state organization has been established (See fig. 6.)

The Medical Department is responsible for the conservation of life and health in a disaster. Its primary objectives are to prevent casualties through initiating known preventive measures, to minimize the extent of injuries and to restore to health in the shortest possible time those who unavoidably are injured.

A comprehensive plan has been written which includes provision for a number of alternate directors of the various essential activities (we cannot over-emphasize the need for alternates familiar with and capable of implementing the plan); mobilization of physicians, nurses, hospital administrators; care of the sick, mentally ill, and communicable disease cases; use of available hospitals and establishment of emergency hospitals; arranging for use of emergency ambulance service; identification of sick, injured and dead; establishment of public health programs for protection of water supplies; establishment of sewage and waste disposal; bacteriological defense; radiological monitoring and decontamination; chemical defense; recruitment and training of necessary personnel. Known agencies, governmental or voluntary, that have a contribution to make have been or are being contacted. The Oregon State Medical Society, in conjunction with the Oregon State Board of Health, sponsored

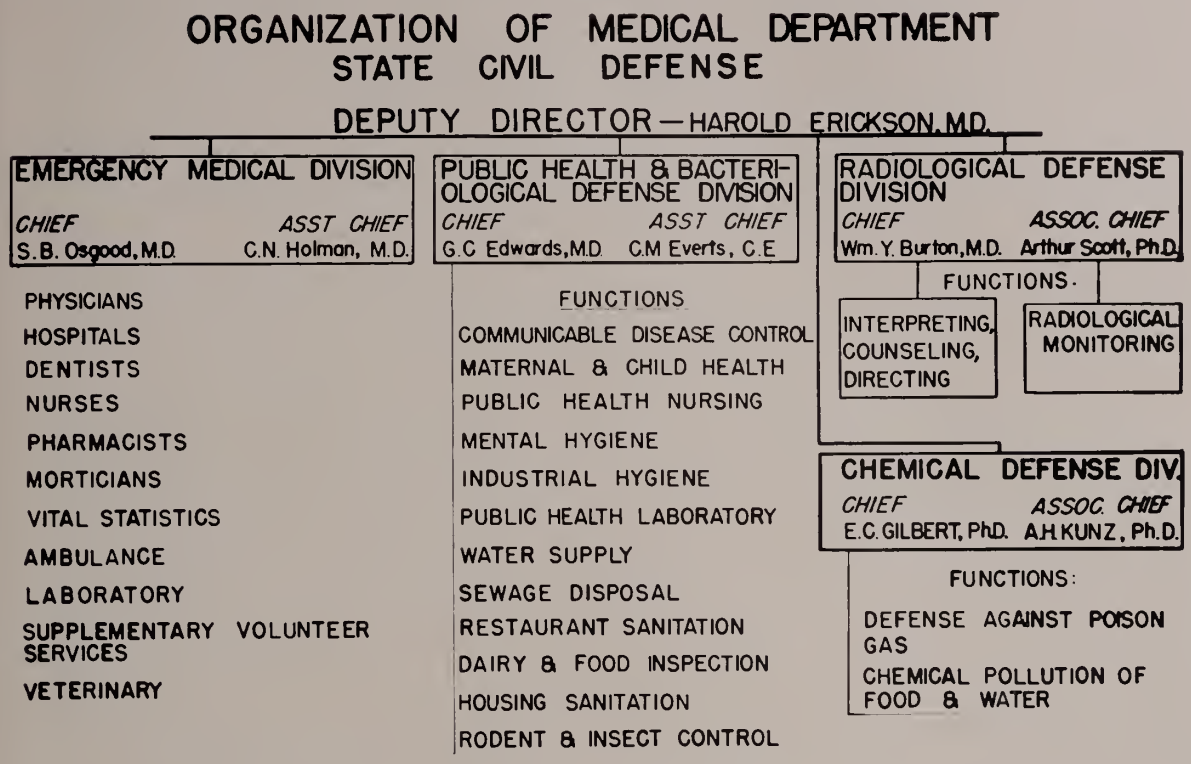


Fig. 6

a one-day institute for chairmen of disaster committees of local county medical societies and health officers. Much valuable material has been gathered together. Data on organization is available.

Cities and counties have been invited to establish civil defense organizations and plans. The City of Portland, Multnomah County, and a few others have been active. However, the greatest weakness in the civil defense program in this state today is lack of organization of all communities of the state. The local unit is the key to the entire plan. Unless every community realizes its responsibility and organizes, the program will fail. In any enemy attack with atomic bombs, Portland might be hit. Cities along the Columbia River may be flooded as a result of destruction of Grand Coulee Dam. In either instance, the help of every community in this state will be needed; in fact, help from neighboring states will be needed. If Seattle is bombed, Oregon's help will be needed. If the populations of larger cities are not kept in the fight, this country will fall. Without industry, our defenses would collapse.

Every doctor has more of a part to play than the average citizen. We are critically needed in a disaster. We are urgently needed *now* to help stimulate local organization, to help allay fear of irradiation; to combat rumors, and to help give information on how the individual may best protect himself. Irradiation is not new. Much can be done to minimize damage and to treat casualties. The physician is in a particularly good position to help disseminate information. His opinion is respected and his advice is sought on any problem related to health. He is trained to meet emergencies. He must take an interest in civil defense and in development of the program.

SUMMARY

There is a desperate need for civil defense. The Armed Services cannot assume this responsibility. Although well under way, organization is far from complete; local units and plans are particularly needed. We do not have all of the answers but much information is available. The help of every individual is needed but the physician's help is indispensable not only following the disaster but now in the planning of effective handling of disasters.



Correction of Cleft Palates by Dental Appliances

E. J. FREDRICKSON, D.D.S.*

SPOKANE, WASH.

PATIENTS with palatal and facial defects labor under handicaps that cannot be fully appreciated by those with normal palates. Although all of us recognize this deformity, too few realize the mental torture, humiliation and misery which it engenders. According to conservative statistics, one in every 1,200 persons is born with a cleft palate; this estimate does not, of course, include the numbers of acquired cases.

Reparative surgery and maxillofacial prosthesis have for centuries been used separately and in an unrelated way for repair of facial defects and deformities arising from accidents, destructive diseases and congenital cleft palate. But it is only within recent years that advantages of combining these two methods have been realized. This point is made especially clear in deformities about the face and jaws, when success of plastic surgery depends among other things upon restoration of the normal contour of the region involved.

In order to establish that contour we must recognize the importance of the underlying framework over which the soft tissues are to be repaired. If bone or cartilage is missing and it cannot be adequately replaced by a plastic procedure, we are obliged to use prosthetic appliances, either as a temporary measure or as a permanent restoration (fig. 1). This point is clearly seen when the teeth, alveolar processes and part of the maxilla are missing. No matter how skillful the plan is in repair of the lip, unless we supply adequate support from within the mouth, we cannot obtain desirable results in the lip and cheeks.

At the present time, the types of obturators and appliances, designed by such pioneers as Kingsley, Martin, Case and Baker, are used rarely because surgical procedures have developed sufficiently to provide a child with a long, mobile velum. However, for several reasons, demand for a new type of prosthetic procedure has been needed. In cleft palate repair, as in other surgical procedures, there are failures and partial successes. When this is the case, the symmetrical outline of the bifurcated soft palate does not exist as it does in cleft palates that have not been operated on. Instead, there may be a closed palate with a large nasopharyngeal space caused by shortness of the soft palate. In the event of complete surgical failure, there is either loss of the soft tissue or scars and adhesions. It

has been found that the maxillae of patients with cleft palates fail to develop, even after successful operations have been performed in infancy. This lack of development results in a retrusion of the upper middle half of the face and gross irregularities of the teeth (figs. 2, 3, 4).

When patients present themselves with palates having definite retrusions of the upper jaw, caused by underdevelopment of the maxillae, for children we advise intelligent orthodontic treatment. If this procedure is handled properly, the results are good. However, for many reasons it is not always possible to carry out this ideal type of treatment. As a result we often see marked deformity of the upper lip in young adults, more from a lack of underlying support than from lack of good early operations. It is not always practical to resort to orthodontic treatment at this stage, but construction of an appliance that will be highly satisfactory from a cosmetic as well as a functional point of view is possible. For a patient of this type, with a marked deformity of the upper jaw, the plan of procedure would be to sacrifice some of the distorted anterior teeth and construct an appliance incorporating fullness equivalent to that of the normal denture. (fig. 5).

Many operations on the lip appear satisfactory from a surgical point of view but results fall far short of approximating the contour of a normal lip as the child grows older. One of the reasons for this is the lack of proper support from the alveolar bones, resulting in shrinkage of the lip tissues. The uneven outline of the vermilion border is another definite departure from the normal lip. Most of these patients have overdevelopment of the lower with underdevelopment of the upper lip. We find this may be corrected by insertion of a properly made obturator or appliance (figs. 6, 7). This paper will attempt to discuss obturators and appliances only.

THE UNREPAIRED CLEFT PALATE

Though the general trend at the present time is toward surgical treatment of congenital cleft palate cases, especially in early infancy, there remain a number of patients who have to be treated mechanically. Fixation of the obturator in this class of dental work is often a difficult problem. With our younger patients, especially, it sometimes seems impossible to obtain good results. It is of the utmost importance to place the obturator as early as possible, to allow proper adaptation of tissues and thus obtain good results in facial contour, in articulation and the act of swallowing.

*Formerly on the staff of Billings Hospital, University of Chicago. The author wishes to acknowledge the co-operation of Mr. R. Grabosky, whose technical ability figured prominently in the construction of the appliances.

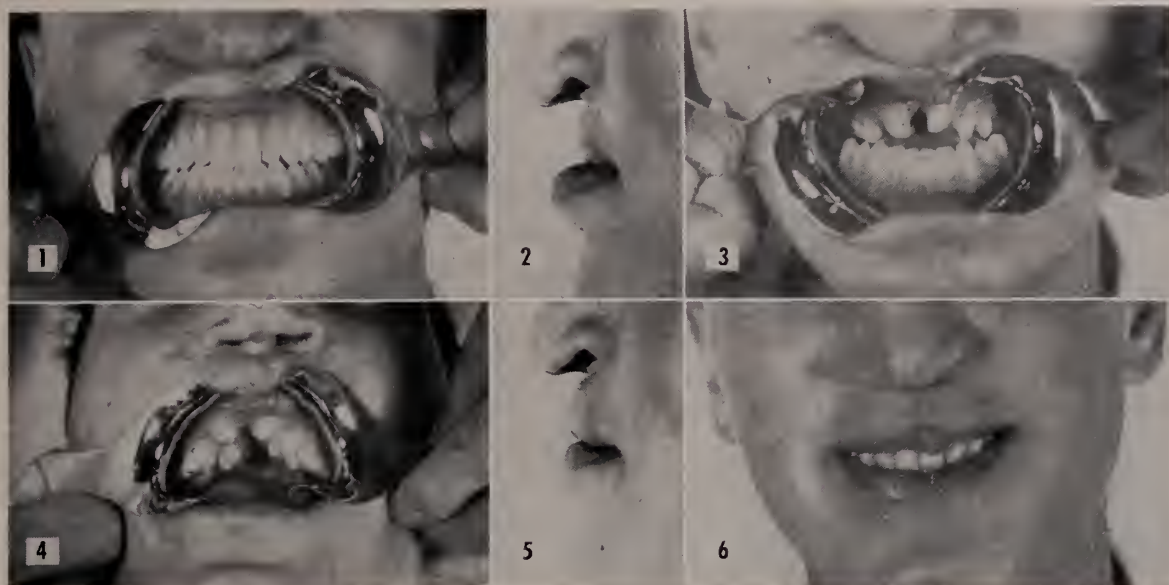


Fig. 1. Inserted Appliance, Incorporating Fullness Equal to that of Normal Denture.

Fig. 2. Retrusion of Upper Middle Half of Face.

Fig. 3. Gross Irregularities of Teeth.

Fig. 4. Gross Irregularities of Teeth.

Fig. 5. Correction of Underdevelopment of Upper Lip.

Fig. 6. Completed Appliance Showing Correction of Dental Abnormalities and Correction of Retrusion of Upper Lip.

Generally at birth the amount of tissue present would be sufficient to form the palate normally. Function is, however, necessary to allow proper further development of the tissues. The child without an appliance tries by all possible means to compensate the closure of the palate and thereby uses the tissue abnormally, so that some parts become hypertrophied, while others show marks of atrophy. It is, therefore, essential to place the obturator at as early an age as possible, to obtain full benefit of the acquirement of the speaking habit, with the help of an elocutionist, because vocal usefulness of the obturator may increase with the age of the patient.

Correct vocal articulation necessitates the separation of nasal and oral cavities to prevent passage of air into the nares. The nasal twang, as commonly observed by neglected cleft palate patients, is a serious drawback for the patient in later life and psychiatrically a depressing factor in childhood. The assimilation of food is interfered with and there is an annoying tendency for the fluid and saliva to pass through the nose. In breathing, the moistening, purifying and warming of the inhaled air before reaching the lungs is lessened. This must convince us of the importance of helping the young patients as early as possible which is by no means a simple procedure. This is the most difficult form of dental work.

In making an obturator, we are attempting to fill a gap between two parts of the soft palate (fig. 7) so as to allow normal function, to form a valve for closing the nasopharyngeal space during swallowing and speaking. If this space were surrounded

by palatal and pharyngeal muscles which are in motion constantly during speech, any appliance must be shaped to conform to the complex movements of these muscles (fig. 8).

Many ingenious appliances have been developed in the past. A detailed description of them is likely to lead to confusion but they are patterned after two distinct mechanical principles. One type is designed to be under the immediate control of the muscles of the soft palate. Such appliances respond to the delicate movements of these muscles and are of the movable or hinge type (fig. 9). The second type is designed as a stationary appliance. These are stationary but are shaped so that the muscles of the palate and pharyngeal groups are always in contact with the lateral and posterior surfaces of the appliance in the various movements.

It has been found that success depends less on the design employed than on the accuracy of adaptation to the patient under consideration. Movable or stationary appliances are mechanically and physiologically practical if applied to the correct case according to the indications.

Each type has certain limitations. The movable appliances cause less strain on the denture and remaining teeth but, being connected to the denture or having similar attachment, they are apt to leak at that point of contact because of the possibility of escape of air. Also, the hinge may require frequent repair and its accuracy is diminished. Stationary appliances are simpler and more durable but exert greater leverage and, as a result, the teeth holding the appliance are under greater strain.



Fig. 7. Gap between Two Parts of Soft and Hard Palate.

Fig. 8. Inserted Appliance, Shaped to Conform to Complex Movement of Palatal Muscles.

Fig. 9. Movable or Hinge Type of Appliance.

For that reason they are not indicated for patients without sound teeth to retain the appliance.

PROSTHESIS FOR THE REPAIRED CLEFT PALATE AND LIP

THE REPAIRED CLEFT PALATE

Most cleft palate cases are mutilated cases which means there are many misplaced or malformed teeth as the result of palate closure. Teeth in or adjacent to the cleft areas are considered poor

risks for treatment appliances, both from the point of view of active treatment as well as from the point of retention. All badly misplaced or malformed teeth in or adjacent to the cleft areas are, therefore, to be condemned and removed surgically. Sound teeth in good repair are considered worthy of retention.

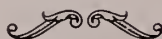
Following completion of the operative work and surgical removal of condemned teeth, appliances are constructed which seem best suited for the individual case. For the child who has not reached full growth and development from the dental standpoint, a treatment appliance is made of all acrylic type. The replacement is so designed as to be secure and well balanced, in order that it may give maximum functional security and give support to lip with the desired esthetic appearance. As the child grows older, the appliance must be replaced from time to time until he has reached full dental growth.

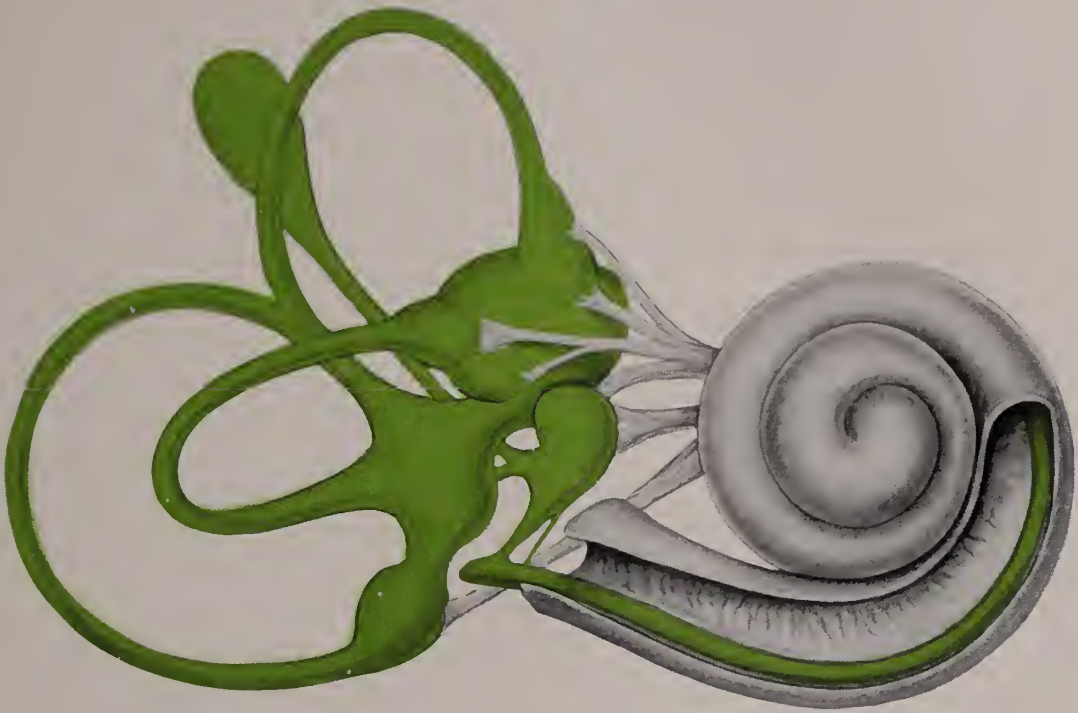
When full growth and development have been attained, the treatment appliance is replaced by a permanent one. The replacement is usually one with a case gold framework and clasps and finished with one of the standard acrylics (figs. 1, 2, 3, 4, 5, 6).

SUMMARY

From the cases presented we can see the necessity of combining reparative surgery and maxillo-facial prosthesis for repair of facial defects. But it is only within recent years that advantages of combining these two methods have been realized. This point is made especially clear in deformities about the face and jaws, when success of plastic surgery depends, among other things, upon restoration of the normal contour of the region involved.

In order to establish that contour we must recognize the importance of the underlying framework, over which the soft tissues are to be repaired. If bone or cartilage is missing and it cannot be replaced by a plastic procedure, we are obliged to use prosthetic restoration. This point is clearly seen when the teeth and alveolar processes and part of the maxillae are missing. No matter how skillful the plan is in repair of the lip, unless we supply adequate support from within the mouth, we cannot obtain desirable results in the contour of the lip and cheeks.





Detail of the Labyrinthine Structure

"The prophylactic value of Dramamine was conclusively demonstrated among 170 passengers who volunteered the information that they were unusually susceptible to motion sickness. . . . There was complete relief (freedom from any signs or symptoms of airsickness) in 152 cases or 89.5 per cent; . . ."

—Tuttle, A. D.: *Special Breakdown of Case Histories*, presented at the Airlines Medical Directors Association Meeting, New York, N. Y., Aug. 28, 1949.

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RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

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**ANNUAL MEETING
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Opinions, Views or Comments presented in articles appearing in this section are those of the individual authors and are not necessarily those of Oregon State Medical Society.

Standards Program Disturbs Our Skeptic

During a lull in the recent festivities at the University of Oregon Medical School conducted by the Portland Surgical Society, your correspondent was wandering idly along one of the passageways, blessed with memories of less turbulent times, when a heavy hand unexpectedly grasped his shoulder and spun him unceremoniously around.

As a matter of record be it noted your correspondent instinctively tended to react to this approach in the manner appropriate to the days running through his mind at the time of the interruption. But the mellowness of passing years and the acquisition of a flabby front have convinced your correspondent his muscular co-ordination may not keep pace with any haymaker desires with the result an embarrassing episode was avoided. For the unseen approacher was none other than our good friend, the Confirmed Skeptic.

"Fancy meeting you here!" exclaimed the Skeptic in the feigned surprise which typifies the droll, hack-saw type of humor he has featured on the occasion of our meetings since the anti-trust legalities played in Judge Claude McCulloch's court and which your correspondent has learned to recognize with the naked eye at a hundred paces. But there was a sparkle in the old boy's eyes which belied his rough approach and announced more eloquently than words that he wished to unburden himself at the absence of the slightest provocation.

"What's on your mind?" surrendered your correspondent, beating him to the punch as a measure to forestall an attack of acute hypertension. "But before you start talking let us go down the corridor a little way lest you decide to wax eloquent and your enthusiasm be mistaken for boisterousness and get us both thrown off the premises."

"Not at all necessary," he countered, refusing to move. "I have mentioned previously I think some of you docs get a little stupid in the head at times. I have stumbled on another such occasion. So I would much prefer to whisper than shout, because there are others who have similar views, and I have no wish to confirm their suspicions."

"Your thoughtfulness is appreciated," I assured him, "but what is this occasion to which you refer?"

"Hospital standards, my friend, hospital standards."

"That's not an occasion," I commented. "It's a program."

"When will you learn not to interrupt? It disturbs my thinking. Of course it's a program. Of the College of Surgeons, isn't it? Surgeons just like those putting on this program you are supposed to be attending? Now will you listen while I continue?"

"With my usual pleasure," I assured him with the amount of tonal sarcasm which former encounters with the Skeptic have proved stimulating. "But the stupidity you mentioned. Where is it?"

"They are trying to give the program away," he exclaimed, waving a menacing forefinger for emphasis. "To hospitals."

"But the College of Surgeons has other things it feels should have first claim on its money," I countered. "Do you blame it for wanting to save money?"

"In that the surgeons are not stupid. In giving the program to the hospitals they are," he insisted.

"But they are not withdrawing their standardization program," I explained. "They are continuing to operate it, even if it is expensive."

"Temporarily only, my friend, temporarily only. Until the machinery for its painless transfer can be set up and sold to your profession. The American Medical Association is now getting into the act and your program will be compromised over to the hospitals."

"Why jump to that conclusion?" I asked. "Don't you know the A. M. A., by resolution of the Board of Trustees and editorially, deplored the announced willingness of the American Hospital Association to conduct the program?"

"That I do, my friend. That I do. Because the A. M. A. was left out of the act, not to mention being caught with its intelligence down. And intention is a better word than willingness. That you should be so stupid!"

"Well," I countered weakly, "the protest stopped negotiations, didn't it?"

"Naaah," mimicked the Skeptic. "Modified is the word, modified. Instead of negotiating without the A. M. A. knowing what is going on, enough working surgeons woke up to the dangers in the situation some

of their fellows created that they wanted none of it. It would be smart to let the good old A. M. A. take over. So what happens? The A. M. A. obliges the surgeons, pats itself on the back for screaming the protest, oils up its compromise machinery and moves into the middle of the picture."

"What's so wrong about that?" I demanded. "The A. M. A. represents the nation's doctors."

"So it likes to think—and have you docs think—but sometimes I wonder. Take what's happening if you don't believe me."

"Go ahead," I urged.

"If the A. M. A. represents American Medicine, why does the American College of Physicians also have to get into the act along with the surgeons and the hospitals? Why not the Radiologists, the Obstetricians and all the other specialties, too? It seems to me they have just as much right to get into the standardization act as the internist and surgical specialty groups. If the A. M. A. is really serious about representing you docs it could sit down with just the College of Surgeons boys and come up with something good on standards. Why bring the hospitals and the rest of them in on it if there isn't some sort of appeasement coming up? Only it won't be called that."

"You have a point," I conceded. "Perhaps you remember our state society tangled with this question of 'whose standards' some time ago and went on record as favoring . . ."

"Yes, I know," interrupted the Skeptic. "You didn't want any specialty group or collection of specialty groups, and least of all hospitals, making standards of medical care. And what happened to your resolution? Don't answer! The A. M. A. sits down with some specialty groups and hospitals and tries to work out a standards program. And you think the A. M. A. represents you. Perhaps it does, but from where I stand I'd say it does only when you force it to!"

"I see you still have doubts about the A. M. A."

"Let us say, rather, a low regard. I am willing to raise it at any time performances justify it."

"Doesn't the performance in the National Education Campaign justify a higher regard?" I asked.

"No. Because it requires little or no brains to recognize a direct or frontal attack designed to socialize medicine, but it takes considerable to recognize and deal with the fringe attacks. If you ask my opinion, you should be worried about this constant picking away at the edges. This could be one of them."

A puzzled look must have crossed your correspondent's face, for the Skeptic continued, "I see you don't follow me, so I'll explain. Some time back you medical chaps were all stirred up about hospitals practicing medicine. You held a big investigation and brought in a report. Hess report, it was called, I think. What happens next? The record has been made so it's filed and forgotten. Meanwhile the hospitals go right on trying to strengthen *their* position and some of your boys aren't smart enough to keep from helping. From what I've been reading lately, you may be winning your fight with the political smarties, that is, the direct fight, but you may be losing ground mighty fast on the fringes. If you let the hospitals add to

their position by taking over any program setting medical standards, you're just plain scuttling your own ship, and not too slowly. With hospitals getting large handouts of your and my tax money from the federals do you think their ability to resist the wiles and encroachment of the socializers is being strengthened? You follow me?"

"You have a point," I had to admit. "Do you have any ideas how the situation should be handled?"

"I should be helping you when I'm not even following your trade!" the Skeptic replied with a sparkle in his eyes which told I had hit pay dirt. "But I can tell you what I'm thinking. I'm thinking since the A. M. A. already inspects hospitals for approval for internships and residents, and inspects medical schools for rating, it would be logical to add any inspections necessary to establish standards of medical care. Can't see where they could be criticized for doing that. It's a medical profession matter, isn't it?"

"It would seem so," I agreed, "but who would determine the standards?"

"Use the present ones, stupid, if they're good; if not, change them and make your own. That's important. *They must be your own*, not ones dreamed up by the specialty boys or hospitals. The A. M. A. could get a set of standards drafted easily. They're good at that. Where they fall down is hanging tough once they have them. That's why I don't like this dickering that's going on with hospital people now. You medicals should look into it before you take another push down the river called compromise. If you get many more of those pushes you'll be trying to see around a curve. And it won't necessarily be a government guy grinning at you from the upper part of the river."

"But don't you think the hospitals should have something to say about standards which might affect hospital operations?" I asked.

"Of course they should. But they can say all that should properly be said in an advisory or liaison capacity. Remember it's standards affecting the medical profession we're discussing. Standards which should be set up by the medical profession itself. That's important, but, of course, you must be fair about it. Well, thanks for listening and it's been nice seeing you again. Make a memorandum of our talk, will you? It should be interesting to see what happens."

So, here is your memorandum, friend Skeptic, and, as I said before, if you don't like the way I report things you should do your own writing.

Now, to keep the record straight, I'd like to add a few observations of my own.

My hunch is, and I've checked the background suggesting it with a prominent member of the College of Surgeons, that the announcement made by the American Hospital Association built enough of a fire under the A. M. A. moguls (which no single resolution from one, or a few, component societies could) to cause unusual editorial and Board of Trustee activity on the part of the A. M. A. This in turn alerted the profession to the dangers involved including many members of the College of Surgeons who hadn't known exactly what was happening. This is the first

ness, rather than the A. M. A. activity, slowed down the "give-away" to a walk. In effect, the surgeons decided NOT to relinquish their standardization program. At least not for some time to come. It appears they have even assessed their individual members a goodly sum for the privilege of continuing its support. So it is most unlikely the standards program will appear under new management in the near future.

A second hunch would be that orderly talks concerning the future of the program will probably take place, looking to some changes which will relieve the American College of Surgeons of the financial burden of a program which in application has been extended beyond the activities of surgeons.

The chances are, under this orderly consideration, any standardization program resulting will probably wind up, not under hospital auspices, but clearly in the medical fold where it belongs. But it *may* not happen that way, as our Confirmed Skeptic anticipates, unless the medical forces from county societies up keep alert to the situation and keep their representatives duly and adequately informed of their wishes in the matter.

GORDON LEITCH

Pete the Pest Says

Fuzzy thinking: Recent meeting held in upstate town, to raise funds for hospital local community is trying to promote, unexpectedly degenerated into intensive bandying of words between prominent local registered nurse and town surgeon, who enjoys sound reputation but also can be downright crabby on occasion.

Meeting was going amicably enough until medico twitted nurse for failure to take stand against socialistic attacks on medical profession. Replying, nurse parroted line put out by national nurse group which claims they should stay "neutral" to avoid getting reputation as political pressure group, and to be "free" to work for patient under any medical plan "chosen" by American people.

Rough talking doc countered with some embarrassing questions. Wanted to know, since basic issue is between free American way of life and socialism, how there could be any "neutral" position? Also wanted to know how any attempt to foist any government plan on people without their vote could be interpreted as a plan chosen by the people? To clinch matters, then asked how nurses expected to be left "free" to

work for patient with government having their necks in a noose?

Now town people are trying to get nurse back into same room with doc in hope of restoring harmony and eventually getting their hospital.

* * *

Hard going: Young Portland doctor, recently entered private practice after long hospital training, is learning at first hand about public relations.

In early February doctor had patient in large hospital for a few days, then discharged him and patient paid bill. Later in February doc again put patient in same hospital, for a different complaint, again for a few days.

When patient left hospital second time he was surprised at size of bill presented by hospital, immediately sought out doc to ask what it was all about. Sez irate patient: "I know the hospital's thinking of building, so I don't mind paying for my first and my second hospital trips. But it's pouring it on too thick when they bill me for *all the time between these* when I wasn't in the joint."

Whazza matter with the guy? Doesn't he know times are tough for hospitals?

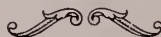
Obituary

GILBERT JOHNSON McKELVEY, 44, Portland orthopedist, died in late February in Minneapolis after a short illness. He had gone there to a department headed by his brother for a chest operation.

Dr. McKelvey was born in Kingston, Ontario, Canada, in 1906 and attended the schools of Kingston where he also took his premedical training. He obtained his medical degree from Queens University, Kingston, and took postgraduate work in Montreal hospitals before a residency in his specialty at Johns Hopkins Hospital, Baltimore.

In 1938 he came to Portland to be associated in orthopedics with the Portland Clinic and the University of Oregon Medical School as associate clinical professor. He spent four years with the armed forces in World War II with the rank of lieutenant colonel, following which he resumed his private work as before.

He was a member of the Multnomah County Medical Society, Oregon State Medical Society, American Medical Association, American Academy of Orthopedic Surgeons and a number of other academic societies connected with his specialty.



WASHINGTON STATE MEDICAL ASSOCIATION



ANNUAL MEETING
SEATTLE, SEPT. 9-12, 1951

President, K. L. Partlow, M.D., Olympia

Secretary, J. W. Haviland, M.D., Seattle

Executive Secretary, Mr. R. W. Neill, Seattle

Report from the State Legislature

The 1951 regular session of the State Legislature ended in confusion, the big controversy being over taxation. The meeting of law-makers also was the longest overtime session in the history of the Legislature.

The overtime period was spent for the most part in wrangling over whether there should be any new taxes and, if so, what they should be. Failure to pass any tax bill threw the state budget approximately \$45,000,000 out of balance. The state already was \$50,000,000 in the red. These facts caused Governor Langlie to veto the appropriations bill and call the legislators back into a special session.

The Legislature, in the special session, faced two problems—paring the appropriations bill to the bone, thus reducing the need for new taxes to a minimum, or leaving the appropriations bill in the same form and amounts in which it reached the Governor and passing a new tax bill that would bring in approximately \$100,000,000 during the next biennium.

Should the appropriations bill be reduced materially, it would mean the state's schools and higher institutions and possibly the Social Security program would suffer the most. The less conservative blocs in both houses would make a determined stand against such reductions. On the other hand, the conservative groups in the Legislature are against any new taxes and have strong support for their position from the people at large.

The legislators truly have a job on their hands.

A couple of million dollars would have gotten them ten millions and a teaching and research hospital for the University of Washington School of Medicine, but the legislators couldn't see it that way.

The law-makers passed a bill which the Governor signed permitting the University Board of Regents to bond the income from the Metropolitan tract in downtown Seattle for the hospital.

They, the legislators, then were asked to appropriate from the general fund \$3,000,000 more. This total of \$8,000,000 presumably would have gotten the University two to three million dollars in Hill-Burton funds (federal), making a total of ten or more million dollars, which would have built the teaching and research hospital.

Instead of appropriating this \$3,000,000 from the general fund, the legislators earmarked only \$1,000,000 of University funds for the hospital, making a total available for the hospital only \$6,000,000, which, with matching money available on that amount, would not have made a total large enough to build a hospital believed desirable by University authorities.

Whether the University regents will bond the Metropolitan tract income for the \$5,000,000, in view of the present circumstances, remains to be seen.

Legislators said but for the opposition to the hospital by a number of Seattle physicians, the \$3,000,000 appropriation from the general fund might have been obtained and the hospital could have been completed this biennium.

Medical Notes

STATE CANCELS MEDICAL-CARE CONTRACTS. Prepaid medical-service contracts, signed about a month ago between the State Health Department and various county medical bureaus for the care of welfare patients, were canceled recently by the department, effective March 31. The action does not apply to King County, where there is no prepaid service contract. Leonard A. Dewey, chief of the medical-service division of the Health Department, said the 30-day cancellation clause in the contracts was exercised because of the uncertainty of the department's finance for the next biennium.

"We will have to wait until the Legislature decides on our appropriation and then plan our program for the next two years," Dr. Dewey said.

MEDICAL-CARE DUTY TO HEALTH DEPARTMENT. The Seattle-King County Health Department has assumed responsibility for the public assistance med-

ical-dental care program. The King County Welfare Department has been handling the program until the Health Department could assume it. The transfer means that the Welfare Department no longer will issue authorizations for medical care under Initiative 178 to persons receiving public assistance. Mr. Elmer L. Guenther, formerly secretary of the health division of the Health and Welfare Council, is administrator of the medical-services division.

PROGRESS MADE ON EMERGENCY MEDICAL CALLS. Medical societies in 329 communities have established night- and emergency-call systems for doctors, the American Medical Association reported in Chicago recently, according to the Associated Press. The King County Medical Society is working to develop such a system, according to Neil Winikoff, executive secretary. In the meantime, there are two medical telephone services through which members of the King

County Medical Society may be found at all times. The King County Medical telephone exchange is Main 6901 and the Doctors' Center is Main 2800.

MEDICAL SCHOOL GETS U. S. GRANT. The United States Public Health Service has granted \$25,000 to the University of Washington School of Medicine for research in protein chemistry, it was announced recently. Dr. Hans Neurath, professor and executive officer of the university biochemistry department, will conduct the studies. He will be assisted by Dr. Frank Tietze, research associate.

STORING "BLOOD FRACTIONS." Against the possibility of many victims suffering from air raids, the government has embarked upon an intensive research in blood for the purpose of speedy and accurate treatment of sufferers from burns, shock and radiation injuries. The problem is that whole blood can be stored for only a few weeks, and then is worthless. More than \$600,000 already allocated for research will be administered by the National Heart Institute. Dr. Leonard Scheele, surgeon general of the public health service, says this year's program will involve the expenditure of perhaps \$2,000,000 in the calendar year 1951 through agreement among several agencies, including the Red Cross and those of governmental departments. Since stockpiling blood per se is out of the question, it becomes necessary through research to purify, use and store constituents of the blood. The plan is to produce "blood fractions" on a large scale when it is determined how most effectively to use them.

Society Meetings

CHELAN COUNTY. Frank B. Queen, professor of pathology, University of Oregon, Portland, was principal speaker at the March 7 meeting of Chelan County Medical Society. He spoke on the effects of ACTH and cortisone on intracellular substance. Meetings of the society are held on the first Wednesday of each month in Wenatchee. Richard F. Stack, formerly of Ephrata, is serving in the U. S. Air Force at Larson Air Force Base.

COWLITZ COUNTY. Regular dinner meeting of the Cowlitz County Medical Society was held at Hotel Monticello, February 21. Alfred H. Illye, dermatologist, Portland, gave an interesting talk on hand eruptions due to various causes. He stressed the importance of an early diagnosis. Many of our hand eruptions in industrial work are due to the various chemicals and other irritants and these must be treated first with mild applications and further contact with the cause eliminated, Dr. Illye pointed out. Cotton gloves worn inside rubber gloves seem to be the best protection that can be given, he said.

C. E. Gantabein, orthopedist of Oregon, discussed ankle dislocations with ligament tears which must be treated by immobilization from four to six weeks. He mentioned that sprains are treated differently and it is very important to make an early diagnosis by X-ray.

SPOKANE COUNTY. Doctors of the Spokane County Medical Society voted at a recent meeting to render free medical care to the children of the orphanages in the area, according to A. Bruce Baker, chairman of

the society's public relations committee. Dr. Baker said the children are taken care of by funds from the Community Chest drive, but the doctors feel that, if their services are provided free, there would be money to spend on other necessary items. The doctors have been rendering this free service to the children for several years.

SPOKANE SURGICAL SOCIETY. Three Spokane surgeons were invited to fellowship in the Spokane Surgical Society at a meeting held February 9. Voting on the invitations followed the election of officers for the organization. Alfred O. Adams, Spokane orthopedic surgeon, was elected president. The post of secretary-treasurer, now held by Fred L. Meeske, carries over two more years. Robert F. Welty and W. H. Tousey were elected to the board of trustees. The new members of the group are Gilman E. Sanford, John K. Burns and Thomas C. Wilder.

WASHINGTON STATE HEART ASSOCIATION. "Seventeen per cent of all deaths between the ages of 5 and 20 are due to rheumatic fever and its complications," Robert A. Tidwell, Seattle pediatrician, told members of the Spokane, Lincoln and Stevens County Medical Societies at a meeting on February 8. Dr. Tidwell and William M. M. Kirby of the University of Washington School of Medicine, spoke at a symposium jointly sponsored by the university and the state department of health. The program, held in the Paulsen Building auditorium in Spokane, was part of the National Heart Month program of the Washington State Heart Association. Dr. Tidwell said rheumatic fever accounts for seven times as many deaths as polio between the ages of 5 and 20, and three times that of tuberculosis. Dr. Kirby described the newest developments in diagnosis of rheumatic fever. The association is trying to raise \$75,000 for research, education and community heart programs throughout the state.

Personal

Welfare Bureau Adds to Roster. (*The Oregonian*, March 8). A Walla Walla physician, whose only dealings with the state welfare department has been treatment of welfare recipients, sent a routine change of address slip last week—and immediately found himself on relief. Dr. George Herbert displayed two checks, one for \$54.48 issued to himself and one for \$54.47 issued to Mrs. Herbert. The checks were accompanied by slips from the state department, showing they were "approved" monthly payments under SCG—senior citizens grant. The department should have an even redder face as a check of its files will show that senior citizens grants no longer are used.

Andrew H. Bloom is now associated in the Doctors' Clinic, Auburn, Wash. Dr. Bloom is a graduate of Northwestern University and served his internship at Swedish Hospital, Seattle.

Robert D. Gengelbach has arrived at the veterans administration hospital in Spokane to head the X-ray division. Dr. Gengelbach comes from the veterans administration hospital at Nashville, Tenn.

F. Lloyd Richardson has located in South Bend where he will be associated with J. C. Proffitt. Dr.

Doctor

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Richardson was graduated from the University of Minnesota Medical School and received his medical degree after a rotating internship at the Minneapolis General Hospital. Since 1949 he has been practicing internal medicine at the Vancouver, Wash., veterans administration hospital.

J. L. Axling, Longview, left February 18 for army duty at Fort Lewis, the first physician in Cowlitz County to be called in the draft of medical men. He was commissioned a first lieutenant and will serve a minimum of 21 months. Mrs. Axling and their three children will remain in Longview.

What happens to the youth of the country in a time of national crisis was the subject discussed by G. Charles Sutch, Richland psychiatrist, in a talk to the Columbia High School P.-T. A. group at its March 1 meeting. In connection with his address, Dr. Sutch showed the film, "Youth and Crisis," which was made during World War II and deals with the induction of young boys and girls into the service.

H. Eugene Patterson, Yakima pediatrician, has taken a year's leave of absence from his practice to take a post at the hospitals of the Harvard Medical School for instruction and teaching in the diseases of children. He was accompanied east by Mrs. Patterson and their three boys.

Harlan McNutt of Port Angeles recently was appointed senior resident psychiatrist at Western State Hospital at Steilacoom, near Tacoma. Dr. McNutt received his medical degree in 1943 from the George Washington School of Medicine and took his training in psychiatry at Bellevue Hospital in New York. He also received a master public health degree from Johns Hopkins Hospital.

Charles A. Rohrmann has been appointed technical assistant to the division head of General Electric Company's technology division at Hanford works. Dr. Rohrmann will assist Dr. R. H. Beaton in coordination of special technical problems of the technology division.

Mayor William F. Devin's appointment of Dr. Sanford P. Lehman as city director of health was confirmed by unanimous City Council vote February 19. Dr. Lehman was previously public health director for Clark County and Vancouver, Wash. He took over his new post March 1, succeeding Dr. Emil E. Palmquist.

Al Dodson, former Ritzville physician, is a naval lieutenant assigned to army elements in Korea. Lieut. (j.g.) Dodson wrote in January that he was attached to the Second Division at Chung Ju in Korea.

Philip L. Westling, Spokane, has become associated with the Grandview Clinic. He has been a member of the staff of the Sacred Heart and St. Luke's Hospital in Spokane. He received his medical degree from the University of Oregon Medical School.

Verne E. Cressey of Spokane became associated with Claude Weitz in Tekoa recently. Dr. Cressey graduated from Northwestern University School of Medicine in Chicago in 1949 and since that time completed his medical training at St. Luke's Hospital in Spokane.

William Saxon, physician and surgeon, has recently opened a practice in Wilbur. He is a graduate of the College of Medical Evangelists in Los Angeles, Calif., and served his internship at Sacred Heart Hospital, Spokane.

Two Seattle doctors have been named among 20 recipients of one of the nation's outstanding medical-science research foundations. Donald F. McDonald, assistant professor of surgery at the University of Washington School of Medicine, and Earl Eldred, an intern at Virginia Mason Hospital, each will receive \$6,000 a year for five years to pursue research at medical schools. Dr. McDonald will do research in the fields of urology and genito-urinary surgery at the university. Dr. Eldred will do research in anatomy and neuro-anatomy at the University of California at Los Angeles School of Medicine.

Hospital News

U. W. HOSPITAL BOND APPROVED. The eagerly sought University of Washington teaching and research hospital moved one step closer to reality recently when the Senate passed a bill authorizing a 5-million-dollar bond issue for the building. The vote was 42 to 0. The revenue bonds would be issuance against income of the University's downtown Seattle Metropolitan tract. Final passage was preceded by Senate acceptance of a House amendment which gave the proposed hospital bond issue a priority on the tract income. The hospital is sought as an adjunct to the University's School of Medicine and Dentistry.

MRS. BALMER AGAIN HEADS HOSPITAL BOARD. Announcement was made recently of the re-election of Mrs. Thomas Balmer as president of the board of trustees of the Children's Orthopedic Hospital, Seattle. Mrs. Balmer first was elected to the board in 1940 and chosen president last year. Mrs. Henry H. Ketcham, president of the board for four years, 1945 through 1949, was elected chairman of the board.

MAYOR WILLIAM F. DEVIN will be master of ceremonies for the dedication program at the new Veterans Administration Hospital on Beacon Hill, Seattle, April 15. Dr. Raymond B. Allen, president of the University of Washington, will introduce Carl R. Gray, Jr., Washington, D. C., national head of the V. A. The hospital will be open to inspection by the public after the dedication ceremony. Thirty veterans organizations and other service groups will participate in the program, according to Don H. Cook, chief of special services at the hospital and general chairman of the dedication committee.

HOSPITAL FUND IS OVER \$33,000. Prospects for building the much-needed proposed addition to the Memorial Hospital, Sedro Woolley, took a healthy upward swing recently with the announcement of sub-

stantial pledges from doctors in Sedro Woolley and Concrete, totaling \$5,700, a \$1,000 pledge from the American Legion and \$250 from the Legion Auxiliary. Another sizeable pledge, payable in cash or lumber at cost, amounting to \$1,000 on the day that ground for the building is broken, was made by Goodyear-Nelson. Other pledges from Sedro Woolley business firms and individuals bring the total amount available to slightly over \$33,000.

Obituaries

DR. JOHN P. LOUDON, 67, died at St. Elizabeth's Hospital, Yakima, February 18, of a cerebro-vascular accident. A graduate of the University of Michigan College of Medicine, Dr. Loudon had practiced in Yakima for 37 years until his retirement in 1946 because of poor health. He was a Fellow of the American College of Surgeons, a member of the staff of St. Elizabeth's Hospital, and served in World War I.

DR. L. M. THOMPSON, 66, Cashmere, died February 7 of coronary heart disease. He came to Washington in 1910 after taking his medical degree at the Louisville Medical College, Louisville, Ky. He subsequently practiced in Colfax, Reardan and Odessa, coming to Cashmere in 1936. He was a Fellow of the American Medical Association and a veteran of World War I.

Auxiliary

Officers of the Woman's Auxiliary to the Washington State Medical Association gathered in Seattle March 2 at the Olympic Hotel with Mrs. Robert

Schulte of Spokane, state president, presiding. After luncheon Dr. Edward L. Turner, head of the University of Washington School of Medicine, spoke on "Practical Aspects of Protection Against the Atomic Bomb."

Twenty members of the Grays Harbor Medical Auxiliary were entertained at a dinner meeting on February 21 in the new home of Mrs. H. I. Weiner in Aberdeen. Guest speaker was Mrs. J. L. Hardy, mother of Dr. William Hardy. Mrs. L. J. Hakala, president of the auxiliary, names the following nominating committee: Mrs. K. D. Graham, Mrs. B. O. Swinehart and Mrs. F. N. Berken. Mrs. M. F. Fuller was named on the library committee. After the business session, the members of the Grays Harbor Medical Society joined their wives for a social hour.

Guest speakers at the February luncheon meeting of the auxiliary to the Clark County Medical Society were Mrs. Raymond Schulte of Spokane and Mrs. Albert Bowles of Seattle. Thirty members of the local auxiliary welcomed the guests in the Officers' Club at Vancouver Barracks on February 6. Mrs. Henry Wiswall, president of the group, presided over the business meeting at which plans were made for the annual benefit tea for the cancer fund, to be held in May. Hostesses for the luncheon were Mrs. Reinhard Becker, Mrs. Wallace Pianka and Mrs. John Bolen.

State Department of Health

Spotlight on Service

Notes on the activities of Washington physicians who volunteer time and effort beyond their regular activities to work with health councils, voluntary health agencies and in other ways to promote better general health. These notes are prepared for NORTHWEST MEDICINE by the Washington State Health Council, a round-table of twenty-two state health groups, with headquarters in the 905 Second Avenue Building, Seattle.

By the middle of April, three physicians will have completed a state-wide "stumping" tour of county medical societies, bringing the latest advances in the prevention and treatment of rheumatic fever to attention of Washington physicians.

The trio includes Robert A. Tidwell, Seattle pediatrician; William M. M. Kirby, research worker at the University of Washington School of Medicine, and Leonard A. Dewey, head of the State Health Department's chronic-disease control section.

The tour was arranged by the Washington State Heart Association and the State Health Department, starting January 2 and running through April 18, covering fourteen different appearances.

The key point in their message is that rheumatic fever, a leading cause of death and disability among children, can be prevented by treating a certain type of streptococcus infection in time with adequate amounts of penicillin.

National recognition is coming to Hinton D. Jonez, Tacoma physician, who founded and directs a multiple-sclerosis clinic at St. Joseph's Hospital, Tacoma.

An article in a national magazine led to 6,859 letters, 223 telegrams and 458 phone calls from outside the state—all from victims of the disease interested in Dr. Jonez' unusual treatment methods.

Patients arriving at the clinic are usually desperate because they have been unable to obtain treatment in their own communities. One arrived with \$3.00 and a .38 caliber revolver in his pocket. "I was really at the end of my rope," he said.

Dr. Jonez' treatment includes the use of curare to relax muscles, histamines, physical therapy and psychotherapy. His work has been aided by the Pierce County Society for Crippled Children and Adults.

William Duncan, Seattle orthopedist, is devoting much time to the cerebral palsy field. He is school physician for the Warren Avenue Spastic School and the Washington State Cerebral Palsy Center in Seattle, as well as a member of the board of the United Cerebral Palsy Association of Washington. Frederick Moll and Robert Ray of the University are holding clinics at the Preschool and Clinic to further studies in this field.

All workers in cerebral palsy, both in this state and nationally, are indebted to the pioneering done in this field by the late Dr. H. J. Wyckoff of Seattle.

A conference pioneering the field of rehabilitation of the epileptic was held at the University of Washington last month, sponsored by the Washington Society for Crippled Children and Adults, the University and the State Health Department. All those interested

in the field were invited, including physicians, nurses, social workers, teachers, parents, employers, labor groups and others.

Three physicians who are part of a clinic team at Seattle's Harborview Hospital explained medical

aspects of epilepsy at the morning session. They included Arthur A. Ward, neurosurgeon; Norman Chivers, psychiatrist, and L. B. Thomas, specialist in electroencephalography. At the afternoon meeting lay leaders discussed the problems of jobs and social adjustment for epileptics.

IDAHO STATE MEDICAL ASSOCIATION



**ANNUAL MEETING
JUNE 17-20, 1951
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Secretary, R. S. McKean, M.D., Boise

Executive Secretary, Mr. A. L. Bird, Boise

Medical Notes

BLOOD COLLECTIONS SET RECORD DURING JANUARY. An all-time high in the amount of blood collected in the Boise region both in the blood center in Boise and on the mobile unit operations, a total of 1,860 pints, was collected during January, it was announced recently.

"This permitted the center to again meet the blood quota set for it by the military," Dr. E. F. Sestero, center director, said.

STATE ACCEPTS MOBILE UNIT FOR TB TESTS. The Idaho Tuberculosis Association recently presented a mobile chest X-ray unit to the state in order that every Idahoan over 15 years of age may receive free X-ray service. Dr. T. O. Carver, who will head the X-ray program, outlined plans of the group.

"The program eventually will offer free X-ray service to every adult in Idaho," he said. "Since tuberculosis is almost non-existent in children under 15, the executive committee decided to X-ray no one under 15 years of age."

The mobile unit was purchased by the association in 1950 with Christmas Seal funds and will be operated by the State of Idaho, Dr. Carver said.

PAUL F. MINER, Boise physician, announced February 8 that the Idaho Heart Association has been accepted for affiliation with the American Heart Association. Dr. Miner, who is president of the Idaho organization, received word of the American Heart Association's approval of the affiliation request from AHA Executive Director Rome A. Betts. He explained that this affiliation will give the organization even greater standing in connection with its forthcoming efforts to raise funds to carry on the research and educational work being carried on by the national organization and within Idaho by the state association.

PAPER ON TB READ AT CLUB MEET. A paper on tuberculosis prepared by Dr. Lois Miller was read at the February 13 meeting of the Bonners Ferry Readers' Club. Especially interesting was the information concerning the use of the X-ray as the state mobile X-ray unit is scheduled to be in that locality in the future.

REGENTS RECEIVE BOOKS OF DOCTOR. The University of Idaho's reference works on medical knowledge have been augmented by volumes from the library of the late Dr. W. F. Robertson of Orofino. President J. E. Buchanan made the announcement recently in listing gifts formally accepted by the board of regents.

TWO HOSPITALS ADDED TO BLOOD CENTER LIST. Two more hospitals, one in northern Idaho and one in eastern Oregon, have been added to the list of hospitals to be serviced by the Boise regional blood center, Dr. E. F. Sestero, center director, announced recently. The addition of these two hospitals now brings to 31 the number of hospitals in the Boise region depending entirely on the region for all blood supplies, he added.

ASSUMES NEW DUTIES. Dr. John K. Helferty arrived in Boise February 5 to assume new duties as assistant chief surgeon at the veterans hospital. Dr. Helferty came to Boise by transfer from the Veterans Administration Clinic at Fort Snelling, St. Paul, Minn.

DOCTOR OPENS OFFICE. James H. Hawley has opened an office in the Eastman Building, Boise, with his practice being limited to surgery. Dr. Hawley recently completed a four-year surgical training course at the Mason Clinic in Seattle.

Society Meetings

NORTH IDAHO DISTRICT. The North Idaho District Medical Society met at the Bollinger Hotel, Lewiston, February 21. Thirty-three members were present. Additional members were elected by the society to complete the membership of the Executive Committee. In addition, appointments were made to the following committees: Public Relations; Orthopedic, Fracture and Rehabilitation; and Cancer. The Board of Censors approved the application for membership of Robert H. Schaeffer and he was unanimously voted into the society. The scientific portion consisted of a very able presentation of various aspects of plastic surgery by Edward Hamacher of Spokane.

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Photo taken ten hours after coitus. Occlusion still manifest.

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Announcements of Meetings

Fluoridation Conference

Friday, April 27, 8:30 a.m., New Health Sciences Building, University of Washington, Seattle.

Sponsoring organizations: University of Washington Medical School, Engineering School—Civil Engineering Department, Department of Public Health and Preventive Medicine, Dental School, Adult Education; Association of Washington Cities; Washington State Department of Health; State Medical Association; Washington Congress of Parents and Teachers, Inc.

TENTATIVE PROGRAM

8:30 a.m.—Registration.

9 a.m.—Welcome and Purpose of Meeting.

9:30 a.m.—Historical Background of Fluoride in Relation to Dental Decay—Fredrick S. McKay, D.D.S., Colorado Springs, Colo.

10:15 a.m.—Recent Epidemiological Dental Caries Studies in Fluoride and Non-fluoride Area—Philip Jay, D.D.S., School of Dentistry, Ann Arbor, Mich.

11 a.m.—Panel on Fluoridation Policies and Viewpoints of Interested Groups in the Field of Fluoridation: 1. Dental. 2. Medical. 3. Washington State Department of Health. 4. P.-T. A. 5. Water Works Operator.

1:15 p.m.—Experience with Evanston, Ill., Fluoridation Project—J. Roy Blaney, D.D.S., Zoller Memorial Clinic, University of Chicago.

2 p.m.—Public Health Aspects of Water Fluoridation in Wisconsin—F. A. Bull, D.D.S., State of Wisconsin Board of Health.

2:45 p.m.—The Engineer's Problems in Fluoridation—Harvey E. Wirth, Assistant State Sanitary Engineer, State of Wisconsin Board of Health.

3:30 p.m.—Systemic Effect of Fluorides; Toxicology, etc.—Leland Powers, M.D., Professor of Public Health and Preventive Medicine, University of Washington.

4 p.m.—Laboratory Control of Fluoridation in Public Water Supplies—a laboratory demonstration.

4:30 p.m.—Group discussion and question period. Discussion leader, David Law, D.D.S., Dental School, University of Washington.

A similar conference, but limited to participation by the out-of-state speakers, will be conducted in Spokane, Saturday afternoon, April 28, sponsored by the Spokane District Dental Society.

American Goiter Association

1951 meeting of the American Goiter Association will be held in the Deshler-Wallick Hotel, Columbus, Ohio, May 24-26. The program for the three-day meeting will consist of papers dealing with goiter and other diseases of the thyroid gland, dry clinics and demonstrations.

FOURTH ANNUAL POSTGRADUATE ASSEMBLY IN ENDOCRINOLOGY INCLUDING DIABETES

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The Olympic, one of Seattle's most delightful hotels, offers special convention rates to members of this assembly. This is an unusual opportunity for you and your family to enjoy a pleasant vacation in the beautiful Pacific Northwest and for you to participate in a highly instructive program of the latest advances in endocrinology and metabolism.

A fee of \$75 will be charged for the entire course and the attendance will be limited to 100. REGISTRATION WILL BE IN THE ORDER OF CHECKS RECEIVED AND WILL CLOSE ON JUNE 4, 1951. Should there be an insufficient number of applicants to fill the course, the registration fee will be refunded immediately in its full amount.

Please forward application on your letterhead, together with check payable to The Association for the Study of Internal Secretions, to Henry H. Turner, M.D., Secretary-Treasurer, 1200 North Walker Street, Oklahoma City 3, Oklahoma, before June 4, 1951. Further information and program will be furnished upon request.

Hotel reservations should be made directly with the Olympic Hotel, Seattle, Washington, and the hotel advised that you are attending this Postgraduate Assembly.

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Tacoma Surgical Club

Guest speaker at the annual meeting of the Tacoma Surgical Club, May 5, 1951, will be Dr. Richard W.



RICHARD W. TELINDE, M.D.

TeLinde, gynecologist-in-chief, Johns Hopkins Hospital. The meeting will be held at Jackson Hall, Tacoma General Hospital Nurses Home. The morning session will consist, as heretofore, of anatomical dissections and demonstrations. The afternoon program will resume at 2 p.m. with the following: Endometriosis, Experimental and Clinical, R. W. TeLinde; Post-Operative Urinary Retention, H. W. Humiston; The Lane Back, W. H. Goering; Pulmonary Embolism—A Case Report, S. F. Herrmann; Hirschsprung's Disease, Surgical Treatment, C. B. Ritchie; Discussion and Question Period, TeLinde. Dinner meeting at 6 p.m., Wedgewood Room, Winthrop Hotel, with address by TeLinde on Urinary Incontinence in Women—Surgical Cure. All members of the profession are cordially invited.

Spokane Surgical Society

Fourteenth Annual Meeting, Saturday, April 21, 1951, Davenport Hotel, Spokane, Washington. Guest Speaker: John M. Waugh, M.D., Professor of Surgery, Mayo Foundation, Rochester, Minn., and Head of a Department of Surgery, Mayo Clinic, Rochester.

MORNING SESSION

- 9:00 a.m.—Introductions and Opening of Meeting, A. F. Cunningham, President, Spokane Surgical Society.
- 9:30 a.m.—The Magnetic Ocular Implant, Robert L. Pohl.
- 10:00 a.m.—Recognition and Management of Spinal Cord Tumors, Howard H. Lander.
- 10:30 a.m.—Surgical Problems in the Aged, Milton W. Durham.
- 11:00 a.m.—Vaginal Hysterectomy for Uterine Prolapse, Peter A. Reiersen.
- Noon—Luncheon, Isabella Room—Surgical Management of Peptic Ulcer, John M. Waugh.

AFTERNOON SESSION

- 2:00 p.m.—Flexor Tendon Injuries, Richard C. Miller.
 - 2:30 p.m.—Injuries About the Elbow, Alfred O. Adams.
 - 3:00 p.m.—Surgical Anomalies in the Region of the Umbilicus, Robert F. Welty.
 - 3:30 p.m.—Thyroiditis, Carl P. Schlicke.
 - 4:00 p.m.—Some Problems in the Diagnosis and Treatment of Non-malignant Lesions of the Lower Esophagus, G. Edw. Schnug.
 - 4:30 p.m.—Carcinoma of the Stomach; Studies Related to Indication for Total Gastrectomy, John M. Waugh.
 - 6:00 to 7:00 p.m.—Cocktail hour, Isabella Room.
 - 7:00 p.m.—Banquet—Informal.
- Address—Diagnosis and Surgical Management of Cancer at Various Levels in the Rectum, John M. Waugh.

Physicians' Art Show

The American Physicians Art Association will have an art exhibit, as usual, during the A. M. A. convention at Atlantic City, N. J., June 11-15, 1951. Any physician in the United States, Canada and Hawaii desiring to participate in this show should communicate with the secretary for particulars. F. H. Redewill, M.D., secretary, American Physicians Art Association, 760 Market Street, San Francisco 2, Calif.

American College of Chest Physicians

The seventeenth annual meeting of the American College of Chest Physicians will be held at the Ambassador Hotel, Atlantic City, N. J., June 7-10. An interesting scientific program has been arranged for presentation at the meeting. The Board of Examiners of the College has announced that the next oral and written examinations for Fellowship will be held in Atlantic City on June 7. Candidates who would like to take the examinations for Fellowship should contact the Executive Secretary, American College of Chest Physicians, 500 North Dearborn St., Chicago 10, Ill. Dr. James M. Odell, The Dalles, Ore., is regent of the college for the Northwest district.

Postgraduate Courses

American Academy of Allergy

A postgraduate course in allergy will be offered by the American Academy of Allergy on June 14, 15 and 16 in Montreal, Canada. It will be sponsored by the Faculty of Medicine, McGill University, and will be held at the Royal Victoria Hospital in Montreal. Any interested physician in the United States or Canada may attend. Fee for the course is \$40. Applications can be sent to Bram Rose, M.D., Royal Victoria Hospital, Montreal 2, Canada.

University of Washington School of Medicine

Practical Psychiatry—July 23-27. This is a course intended primarily for general practitioners. One-hour lectures will be given each morning and afternoon. These will be followed by visits to clinics for a study of patients illustrating psychoneurotic and psychosomatic problems commonly encountered in every-day office practice. Tuition fee: \$50.

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Maybe not all physicians are poor patients. A good friend had a combined abdomino-perineal not long ago. While struggling to get the colostomy to function he was able to keep the spirits of his visitors up by wise-cracking about his troubles. Says he is going to establish the *Order of the Phantom Recti*. Seems an absent rectum can phantom just like an absent leg. The urge to relieve a distended lower bowel is just as real as ever but no way to satisfy it. Not many of us could find that kind of humor when on the receiving end of surgery.

Navy sends in a long communication about appointment in the Medical Corps. References 1, 2, 3, 4, etc., etc. Inquiries to be directed to Director of Naval Officer Procurement, Seattle, Apparel Building, First Avenue and Union Street, Seattle, Wash.

Resodec is the name of an interesting new product by Smith, Kline and French. Called a cation exchange resin it has the property of binding sodium to its large molecule and carrying it out with feces. Now, perhaps, the cardiac can eat his salt and not have it, too.

Did you ever take out a late gangrenous appendix with the stump and cecum so friable that you could

hardly ligate or invert? W. H. Prioleau writes in *The American Surgeon* for February about putting a mushroom catheter into the cecum in such cases. The resulting fistula heals without much difficulty after the catheter is removed seven to fourteen days post-op.

Theories of virus etiology for cancer seem to be gaining new interest since the electron microscope has been brought to play on the problem. Most of those who look for them can find virus-sized bodies in cancer tissue. Bostick at the University of California may have come up with rather good proof of virus in Hodgkins tissue. The race to find the answer to the cancer problem keeps getting hotter.

The New England Journal says, "Old-age relief is limited by the money spent on killing or preparing to kill the youth."

A new anticoagulant, related to dicumarol, may be considerably more potent, less apt to permit hemorrhage. It is still under investigation.

The antibacterial detergent pHisoderm with Hexachlorophene has been renamed pHisoHex.

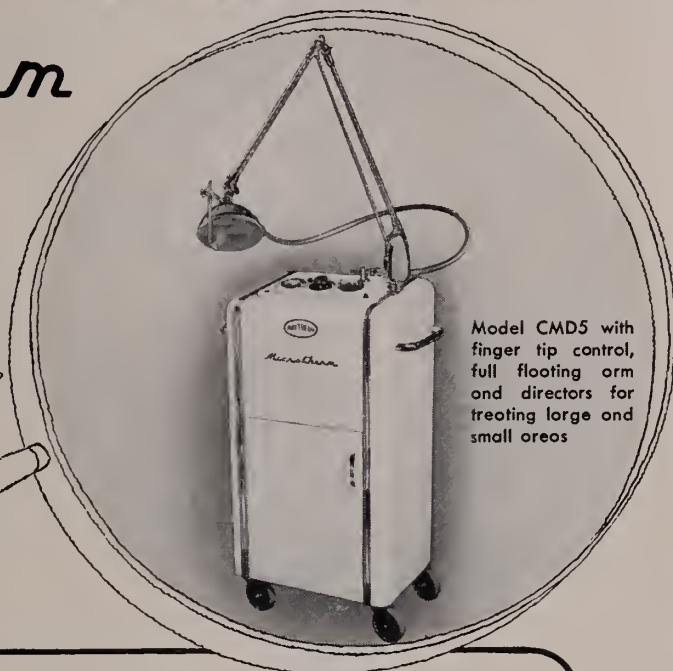
Metropolitan Life Insurance Company enjoys reporting maternal mortality for 1950 the best ever—less than one per thousand live births. Then the report goes on: "In 1948 Oregon had a maternal mortality of only 0.4 per 1,000 births, and Washington, Utah and Connecticut had rates that were only slightly higher. It now remains for the other states to do as well."



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Book Reviews

PARS PRO TOTO. By Alfred Peyser. 196 pp. Almquist & Wiksell, Stockholm, Sweden, 1950.

Handy, pocket-size volume, nothing but abbreviations. From, A. (int) chem Argon, med Anaesthesia to Z. Z' Z". (d) med zunehmende Auckungen. Abbreviations listed alphabetically in bold-face letters; language indicated in parentheses, scientific field in italics. There are nine language classifications and thirty-six scientific field groups. Useful if you need to translate things like U.N.S.C.C.U.R. or G.L.E.E.P. (United Nations Scientific Conference on the Conservation and Utilization of Resources—Low Power Graphite Pile.)

H. L. H.

BASIC PRINCIPLES OF CLINICAL ELECTROCARDIOGRAPHY. By Hans H. Hecht, M.D., Associate Professor of Medicine, University of Utah School of Medicine, Salt Lake City, Utah. 88 pp. Price \$2.00. Charles C. Thomas, Springfield, Ill., 1950.

This is not a textbook of clinical electrocardiography but a monograph which correlates the various basic principles that are involved in arriving at accurate electrocardiographic interpretations. The author demonstrates the rationale for routinely recording semi-direct precordial and unipolar extremity leads. The use of these leads amplifies and supplements the information obtained from the standard limb leads. The reader is made aware that clinical electrocardiography is a growing science. Developments in the fields of vector analysis and especially of spatial electrocardiograms are opening new horizons that will greatly enhance the clinical value of electrocardiography. One regrets that a monograph so short as this one necessarily must limit the length of discussion that can be devoted to each subject.

SAMUEL F. ARONSON

CHILD PSYCHIATRY IN THE COMMUNITY. A Primer for teachers, nurses, and others who care for children. By Harold A. Greenberg, M.D., Senior Staff Psychiatrist, Institute for Juvenile Research, Chicago; Julian H. Pathman, Ph.D., Chief Psychologist, Downey Veterans Administration Hospital, Downey, Ill., etc.; Helen A. Sutton, R.N., B.A., B.S., formerly Psychiatric Nursing Instructor, University of Illinois, and Marjorie M. Browne, B.A., M.A., Instructor, School of Social Service Administration, University of Chicago. 292 pp. Price \$3.50. G. P. Putnam's Sons, New York, 1950.

This book of 292 pages fully measures up to its subtitle. The authors' main goals are to present clearly the operation and values of the child guidance clinic in the community and to clear up any misconceptions about psychiatry and child guidance. With this knowledge it is felt that teachers and nurses can better assist disturbed parents and children in obtaining the expert services available to them.

The material is presented in three main divisions: I. *The Child*, outlines a dynamically oriented theory of personality, psychopathology, diagnosis, prognosis and treatment. II. *The Clinic Team*, describes succinctly the cooperative and interdependent functions of child psychiatrist, social worker and psychologist in

diagnosis and treatment of the child and parent. III. *The Clinic and the Community*, emphasizes the importance of psychiatric consultation in children's hospitals, institutions and schools. A realistic perspective is maintained throughout by an excellent choice of clinical examples. In addition, it is made clear that a reciprocal relationship exists between the clinic and the community—the more effective each one is, the greater will be the mutual benefits.

Medical students and physicians who desire a brief, concise and accurate orientation regarding the functions of a child psychiatrist and a child guidance clinic can profitably read this book. Also references to more technical material are included.

The main criticisms are minor ones. Literary finesse is sacrificed for simplicity in presenting a highly factual and technical subject. Unfortunately, little mention is made of the fact that there are private clinics and psychiatric resources, many of which do essentially the same work as described by the authors.

Special credit is due the writers for seeing a specific educational need in the community and for making a worthy contribution toward meeting that need.

F. S. BOBBITT

PRINCIPLES OF GENERAL PSYCHOPATHOLOGY. An Interpretation of the Theoretical Foundations of Psychopathological Concepts. By Siegfried Fischer, M.D., Clinical Instructor in Psychiatry, University of California, formerly Professor of Psychiatry and Neurology, University of Breslau. 327 pp. Price \$4.75. Philosophical Library, New York, 1950.

Early portions of the book are devoted largely to a review of certain mental processes such as memory, thought, intelligence, emotions, and their pathological deviations. Considerable delineation is undertaken so as to establish exactness of definition as well as concept. Material in the first ninety pages is consequently difficult and tedious and may easily discourage the non-specialist reader. Those who get as far as the chapter dealing with emotions will find readability becomes more fluid and continues so for the remainder of the book.

Tenets of Freudian Psychoanalysis are treated critically and yet with respect and a high degree of objectivity. For the interested specialist, I would consider the book as worth-while; for the interested average non-specialist, large areas will perhaps be disappointing.

BERNARD J. PIPE

COMPULSORY MEDICAL CARE AND THE WELFARE STATE. By Melchior Palyi. An Analysis based on a special study of Governmentalized Medical Care Systems on the Continent of Europe and in England. 156 pp. Price \$2.00. National Institute of Professional Services, Inc., Chicago, Ill., 1950.

This is a small paper-bound volume which is happily printed in a relatively large type on a non-glare paper. There are the usual typographical and other minor errors which are considered to be in proportion to those found in any initial edition.



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The text of the book is a historical account of various technics used to establish various systems of socialized medicine in those countries where it is now found. The author gives his evaluation and comparison of the various forms of socialized medicine based on his personal experience. He points out the defects of these.

The book is one which is most likely to appeal to the busy reader who prefers to learn by use of the outline method in order to fix the broad principles of a current problem in mind. Its usefulness is limited because the vocabulary is too large for the general public's consumption. It is not a book likely to have a neutral reader reaction.

A. D. BAER

MEDICAL TREATMENT IN OBSTETRICS AND GYNECOLOGY. By C. Frederic Fluhmann, B.A., M.D., C.M., Clinical Professor of Obstetrics and Gynecology, Stanford University School of Medicine, San Francisco; Assistant Visiting Obstetrician and Gynecologist, Stanford-Lane Hospitals, etc. 157 pp. Price \$3.00. The Williams & Wilkins Co., Baltimore, Maryland, 1951.

The dust jacket of this book contains a note, "Dr. Fluhmann was formerly Associate Professor of Obstetrics and Gynecology at Stanford University. After a number of years (18) he resigned this position in favor of private practice. As time went on he found himself constantly having to look things up: the minute details of therapeutic measures, special and minor points of all sorts . . . He began to keep a notebook . . . That is the source of the present volume." The result is 145 pages of easy-to-read type in a semi-outline form.

There are four chapter headings: (1) Diagnosis & Medical Therapy in Obstetrics & Gynecology; (2) Therapeutic Measures, Including Useful Drugs, Sulfonamides and Antibiotics, Hormones of Reproduction and Vaginal Douches; (3) Nutrition; (4) Office and Hospital Procedures.

The first chapter is alphabetically arranged: Obstetrics from Abortion to Vomiting of Pregnancy and Gynecology from Amenorrhea to Vulvo-vaginitis. This makes for ready reference.

This is more than a personal notebook, in that the author mentions forms of treatment which he does not employ himself, such as the use of stilbestrol for the woman who does not nurse her baby; and he often gives a brief paragraph on the symptoms and pathogenesis of a disease. In the discussion of pain relief in cervix cancer, he wanders from the subject of his book, Medical Treatment, into a discussion of prefrontal lobotomy.

The section on infertility is very good and, as would be expected from the author of a monograph on the subject, the discussion of Menstrual Disorders is excellent. He usually refers first to injections of estrogens and then to oral therapy, although the choice of routes should be reversed. At the end of a good discussion of Chronic Gonadotrophin, he says, "In obstetrics and gynecology it is no longer considered of much help." In a book designed for quick reference, such statements are more valuable at the beginning of the paragraph.

The section on office procedures is good. The author

probably did not intend this book for the physician who does a large obstetrical and gynecological office practice, but for the interne or resident who is steeped in hospital work and totally unprepared for office patients. This is a very valuable book to take into the new office. It is ideal for the military doctor who finds himself assigned to the care of dependents. It is small enough to lie in the desk drawer, where it could prove a true friend to the internists, general surgeons and others of the brethren who can't avoid doing a little office gynecology.

EDWIN T. MACCAMY

INDICATIONS FOR AND RESULTS OF SPLENECTOMY. By Frederick A. Collier, M.D., Alexander Blain, III, M.D., and Gould Andrews, M.D. From the Departments of Surgery and Medicine, University of Michigan Medical School, Ann Arbor, Mich. 100 pp. Price, \$2.25. Charles C. Thomas, Springfield, Ill., 1950.

This terse and easily read 97-page monograph clearly outlines the criteria for performing splenectomy and the results to be anticipated. A series of 132 elective splenectomies, performed at the University of Michigan Hospital during the past 15 years, forms the basis for the discussion.

In every case a thorough clinical and laboratory investigation was made before and after surgery and a follow-up study was obtained. Each clinical condition in which elective splenectomy is of value is briefly discussed and then the authors' own results in such cases are presented.

The results reported and the indications selected are representative of present surgical thought on this subject in large teaching centers. This monograph should aid the general practitioner, the internist and the surgeon in selecting suitable cases for splenectomy.

ALFRED SHERIDAN

URGENT DIAGNOSIS WITHOUT LABORATORY AID. A discussion of the external signs of conditions which threaten life. By Prof. Dr. Hanns L. Bauer, a.o. Professor of Internal Medicine, University of Munich, Formerly Medical Director and Physician-in-chief, Hospital Munich-Schwabing. 85 pp. Price, \$2.00. Charles C. Thomas, Springfield, Ill., 1950.

This is an 85-page monograph on physical diagnosis that brings to mind the dramatic findings of the critically ill and dying patient.

The material is well written and for an evening's pleasure is easy reading. The book makes a good effort to place less reliance on laboratory and radiological findings and urges the physician to study the patient more. The chapters dealing with the respiratory findings in cardiovascular-renal and pulmonary diseases are in some detail, Cheyne-Stokes respirations and the respiratory findings of patients with coronary thrombosis are covered quite completely.

It is an excellent book for the medical student beginning rounds on hospital wards and for the practitioner it is interesting to note how many patients and situations we have seen fit so well into the descriptions by the author.

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ASPHYXIA NEONATORUM. Its Relation to the Fetal Blood, Circulation and Respiration and Its Effect upon the Brain. By William F. Windle, Ph.D., Sc.D., Professor of Anatomy and Chairman of the Department of Anatomy, School of Medicine, University of Pennsylvania, Philadelphia, Pa. 70 pp. Price, \$2.00. Charles C. Thomas, Springfield, Ill., 1950.

This monograph should be of practical value and interest to any physician connected with childbirth. It presents in a brief but concise manner the research leading to our present-day knowledge of the factors contributing to asphyxia in the newborn. Almost one-third of the monograph is devoted to the detrimental effects on the newborn caused by clamping the umbilical cord before placental separation has occurred. The author points out this can be the equivalent of depriving the infant of one-fourth of its total blood volume.

In the remainder of the monograph excellent studies are presented dealing with fetal circulation, intra-uterine respiration, conditions causing aspiration of amniotic fluid and studies on cerebral damage caused by asphyxia.

Dr. Windle is an authority on this subject. The monograph is well worth reading.

M. P. STARR.

THE SCIENCE OF HEALTH. Second Edition. By Florence L. Meredith, B.Sc., M.D., Fellow of the American Medical, American Public Health, and American Psychiatric Associations. 452 pp. Price \$3.75. The Blakiston Company, Philadelphia, Pa., 1951.

This second edition of Dr. Meredith's textbook of hygiene is divided into five parts. The first part discusses the national health situation and gives a rather superficial outline of the structure of the human body. The second part deals with the daily maintenance of health, with sections on, "taking in supplies," "doing work," "renewal of energy," "keeping clean," etc. Part three is a seventy-page resume of the health problems of the United States, discussing both communicable and non-communicable disease. Part four discusses mental health and is in some ways the best portion. Physiology of the nervous system, "health and personality," "the self-impulse," "the social impulse," "the sex impulse," are discussed in rather idealistic manner. Part five, entitled "The Next Generation," deals with the anatomy and physiology of reproduction, with a section on heredity and parental care. There is a good index, and a bibliography.

Intended as a framework for lectures on hygiene, the book sketchily covers tremendous territory, ranging from the personal problem of constipation to the making of a socially adjusted being.

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	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro-intestinal System	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio-vascular System	Rapid heart rate Peripheral vasoconstriction	Slow heart rate Vasodilatation
Functional Manifestations	Palpitation Tachycardia Elevated blood pressure Dry mouth and throat	Heartburn Nausea-vomiting Low blood pressure Colonic spasm

The data here tabulated is from references 3,4,5,6,7, given below.

When the clinical picture is suggestive of functional disorder, the diagnosis is supported by the presence of the following indications of autonomic lability:

Variable Blood Pressure
Body Temperature Variations
Changing pulse rate
Deviations in B. M. R.
Exaggerated Cold Pressure Reflex
Oculo-Cardiac Reflex Abnormalities
Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relieving the somatic disturbance to prepare the patient for psychotherapy*; 2) guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

*Drug treatment using adrenergic and cholinergic blocking agents in conjunction with sedatives, 8,9,10.

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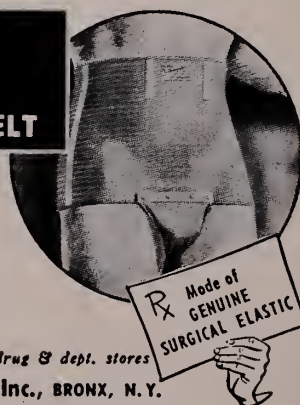
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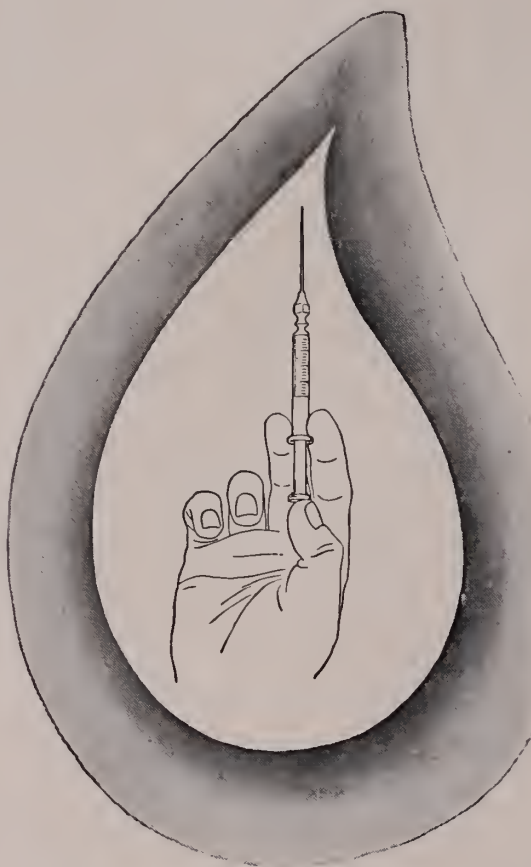
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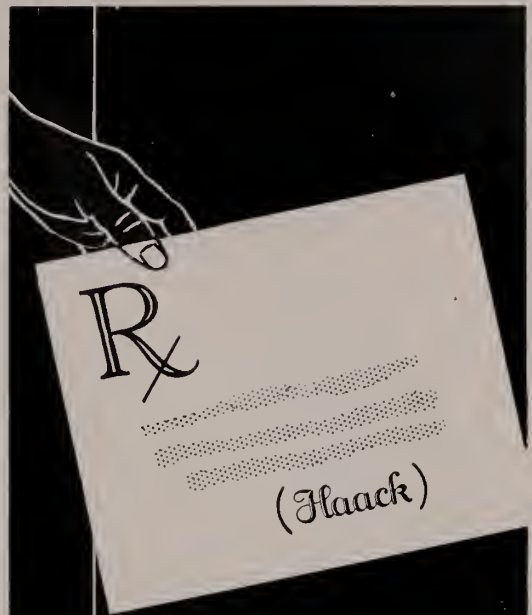


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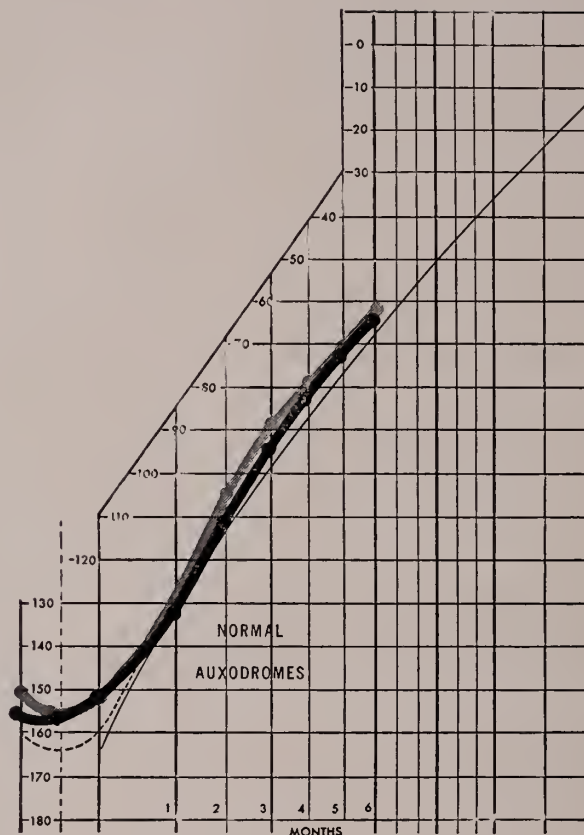
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Hamblen, E. C.: Some Aspects
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North Carolina M. J.
7:533 (Oct.) 1946.

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	Ps. aeruginosa	1	0	1	0
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	Ps. aeruginosa	3	1	0	2
	P. vulgaris	1	0	1	0
	A. aerogenes	1	1	0	0
	TOTALS	32	26	4	2

Douglas, R. G.; Ball, T. L., and Davis, I. F.: California Med. 73:463 (Dec.) 1950

*"A good result was recorded when in 72 hours or less the temperature fell to normal, the pyuria cleared, a negative culture was obtained and the patient was symptom-free."

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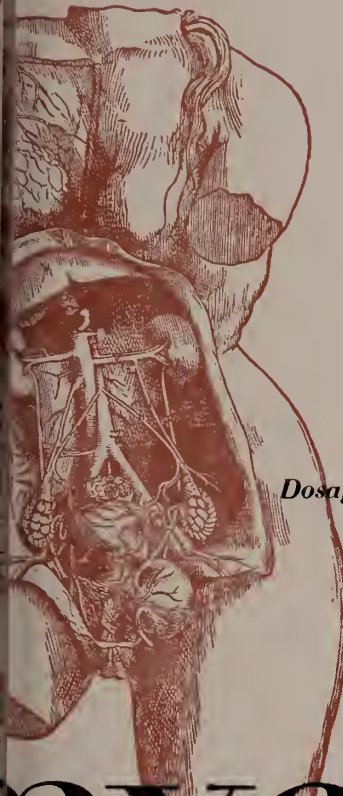
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- American Medical Association**.....Atlantic City, June 11-15, 1951
Oregon State Medical Society.....Portland, Oct. 10-13, 1951
President, W. J. Weese Secretary, R. F. Miller
Ontario Portland
Washington State Medical Association.....Seattle—Sept. 9-12, 1951
President, K. L. Partlow Secretary, J. W. Haviland
Olympia Seattle
Idaho State Medical Association.....Sun Valley—June 17-20, 1951
President, R. T. Scott Secretary, R. S. McKean
Lewiston Boise
Alaska Territorial Medical Association,
Ketchikan—May 31-June 2, 1951
President, D. Cramer Secretary, W. P. Blanton
Ketchikan Juneau

PERIODICAL SOCIETY MEETINGS

NORTHWEST

- North Pacific Society of Neurology and Psychiatry**,
April 20-21, 1951—Victoria, B. C.
President, C. P. Larson Secretary, G. B. Haugen
Tacoma Portland
North Pacific Orthopedic Society.....Sun Valley—May, 1951
Secretary, J. K. Burton President, W. H. Goering
Boise Tacoma
North Pacific Pediatric Society.....Seattle—March 10
President, Gordon Matthews Secretary, S. J. Babson
Vancouver, B. C. Portland
North Pacific Surgical Assn......Vancouver, B. C., Nov. 16-17, 1951
President, S. F. Herrmann Secretary, J. A. Duncan
Tacoma Seattle
Pacific Northwest Society of Pathologists
April 6-7, Timberline Lodge, Mount Hood
President, C. P. Larson Secretary, G. A. C. Snyder
Tacoma Portland

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- Central Willamette Society**.....Second Thursday
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Corvallis Corvallis
Oregon Academy of Ophthalmology and Otolaryngology—Third
Tuesday, Old Heathman Hotel, Portland
President, R. S. Fixott Secretary, G. E. Chamberlain
Portland Portland
Oregon Pathologists Association, Second Wednesday—Portland
President, V. D. Sneed Secretary, J. E. Nohlgren
Portland Portland
Oregon Radiological Society—Second Wednesday—University
Club, Portland
Secretary, C. T. Jessell
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Portland Academy of Pediatrics.....First Monday
President, S. G. Babson Secretary, Edward Rector
Portland Portland
Portland Surgical Society.....Last Tuesday
President, J. M. Roberts Secretary, J. W. Nadal
Portland Portland
Southern Oregon Society.....May, 1951—Klamath Falls
President, H. B. Currin Secretary, F. C. Adams
Klamath Falls Klamath Falls

WASHINGTON

- Puget Sound Academy of Ophthalmology and Otolaryngology**
.....Third Tuesday—Seattle or Tacoma
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Seattle Seattle
Seattle Academy of Internal Medicine.....April 23
President, J. M. Bowers Secretary, W. E. Leede
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Seattle Academy of Surgery.....Third Friday
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President, Gert Heilbrunn Secretary, E. W. Haertig
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Seattle Surgical Society.....Second Friday
President, J. A. Duncan Secretary, R. B. Hearne
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Spokane Surgical Society.....Annual Meeting April 21, 1951
President, A. F. Cunningham Secretary, F. L. Meeske
Spokane Spokane
Washington State Obstetrical Society.....Seattle—April 7, 1951
President, C. D. Kimball Secretary, E. G. Layton
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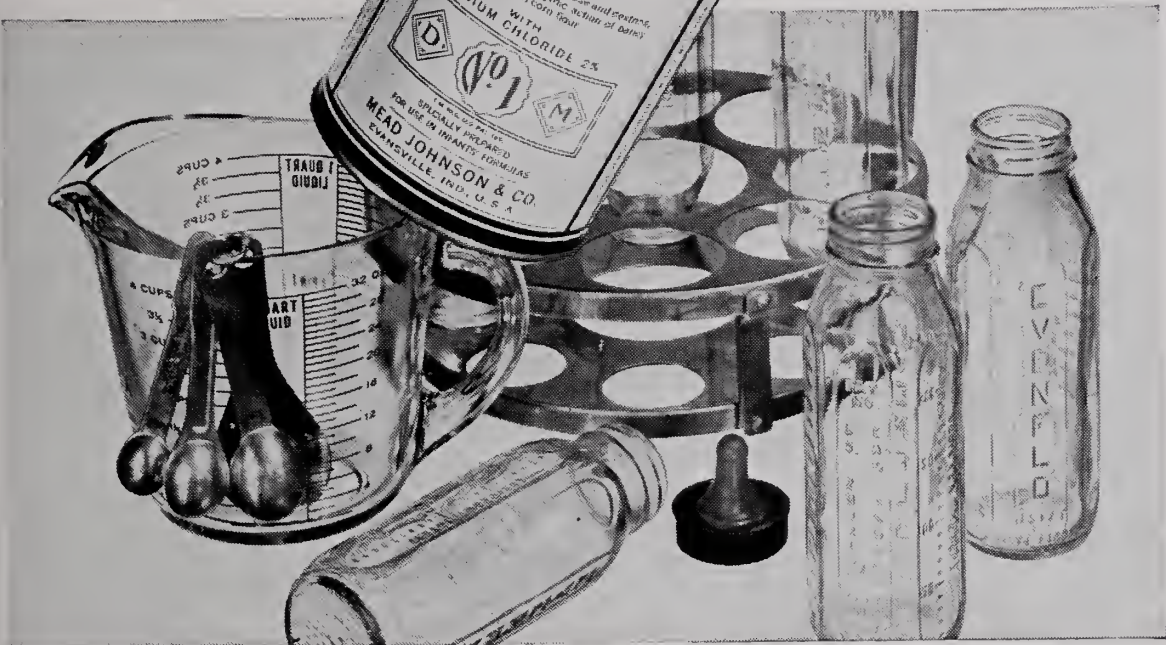
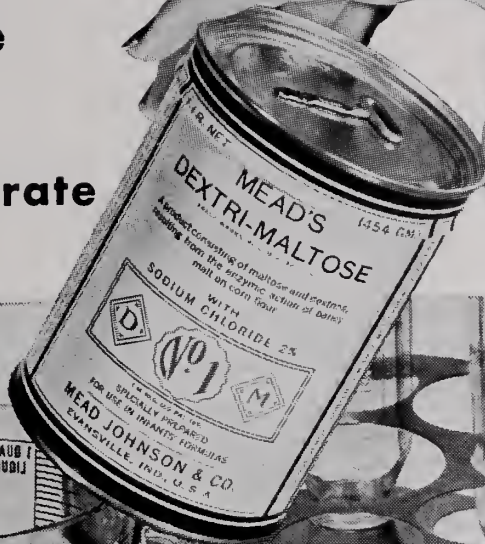
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Vol. 50

MAY, 1951

No. 5

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Medicine's Problem Child, The Hospital (concluded)

Infections in Animals Transmissible to Man—Meyer

Alaska Annual Meeting—Alaska Section

Idaho Annual Meeting—Idaho Section

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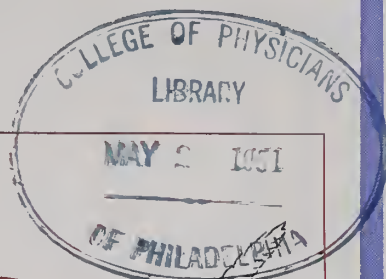
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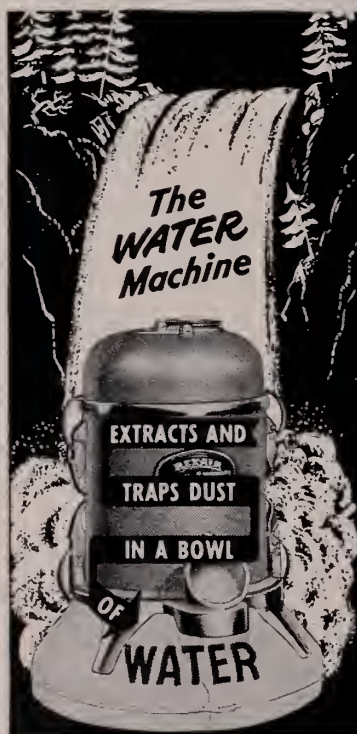
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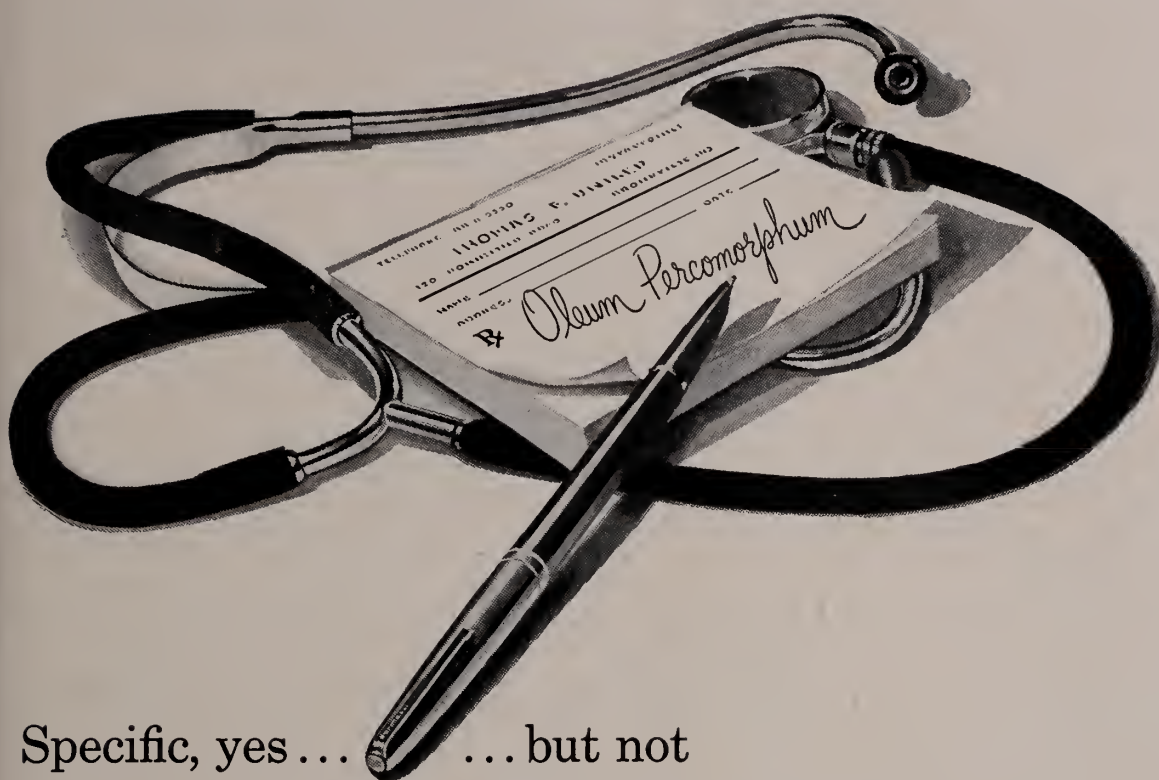
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Cheers for Chubby is the title of a new movie on obesity. It is an eight-minute animation in color and will be shown in theatres throughout the country. The Metropolitan Life Insurance Company which produced the film will make it available to state and county societies on request.

Schering Corporation announces a new steroid under trade name of *Methostan*. It is methylandrostenediol, related to testosterone. Principal action is in nitrogen retention, thus favoring protein anabolism. It retains the protein-building action of testosterone minus virilization. It is recommended that high protein diet and vitamins be supplied when the new drug is used.

Someone will have to think up a new job for toupe makers. Looks like they would be out of business when this new pituitary hormone for baldness gets going. Maybe they should become barbers.

Intriguing theory on rheumatism and arthritis appears in *The Journal Lancet* for March. M. G. Good of London thinks arthritis other than rheumatic fever may be due to what he calls rheumatic myopathy. Importance of skeletal muscle as an organ has probably been overlooked. It is the largest organ in the body and contains about one-third of total blood volume. He explains technic of picking out "myalgic spots" (not to be confused with trigger points) and urges use of 2 per cent procaine. Claims spectacular relief in typical rheumatism patterns and even in rheumatoid arthritis.

Now you can say you have seen everything (in plastics). Lucien Leger of Paris puts in an acrylic prosthesis after fractures of femoral neck necessitating removal of the head. The thing looks like a huge upholsterer's nail. Article is in *Journal of International College of Surgeons* for March.

How good is an athlete's heart? Years of research on this question are reported by T. K. Cureton (Ph.D.) in *Illinois Medical Journal* for March. One of his tests—the progressive pulse ratio test. Determine sitting pulse rate. Have subject step up and down on 17-inch stool twelve times in precisely one minute. Count pulse with stethoscope for two minutes starting ten seconds after exercise. Divide by sitting rate. After pulse has leveled off subject does next rate of stepping. Stepping rates are 12, 18, 24, 30, 36. Pulse ratios are plotted against stepping rates. Good heart gives straight line. Poorly conditioned hearts usually have steeper angle and slope may break after 24 steps per minute. Might be a much better test for office use than counting pulse two minutes after exercise.



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A physician was one of the great American pioneers. He has been described as active and ambitious, strong and stalwart, determined and adventurous, versatile and aggressive, fearless and compassionate, dogmatic and religious. There is no need to spare the rhetoric in describing him. No pantywaist could have filled his sturdy boots in his time and place. He lived, built, led and was murdered by Indians more than a hundred years ago. Now physicians of the Northwest should send contributions toward erection of his figure in Statuary Hall—to the Marcus Whitman Foundation, P. O. Box 357, Walla Walla, Wash.

Local alkaline phosphatase has been found to stimulate calcification in experimental fractures in rabbits. The report by Everett D. Jones of Baltimore is carried in the April issue of *The American Journal of Surgery*.

Sad but true. Last year 35,500 were killed in traffic accidents. • The injured totaled 1,799,800. • Saturday and Sunday are the most dangerous days of the week in traffic. • Danger of being killed in traffic is three times greater between 7:00 and 8:00 in the evening than 7:00 to 8:00 in the morning. • Male drivers were involved in more than 90 per cent of all U. S. automobile accidents in 1950.

Being designated as a rat may not be such an unenviable epithet after all. Seems rats tolerate large amounts of cholesterol without developing arteriosclerosis.

Population of the world in 1949 was 2,378,000,000. Most of them were probably out fishing on Opening Day.

Narcotics Bureau is keeping a close eye on the trade. They report recent dumping of 500 tons of opium on the market at Hong Kong by Communist China.

A New York school teacher has a neat method of demonstrating the way socialism works. When a bright, hard-working student makes a grade of 95 and a poorer student makes 55 he suggests taking 20 from the hard worker and giving 20 to the less able scholar. Thus each would contribute according to his ability and receive according to his need—good socialist dogma. If he would do this for the entire class they would all have something around 75—the minimum needed for “survival.” Students quickly see that the able members of the class would work less, the less able practically not at all.

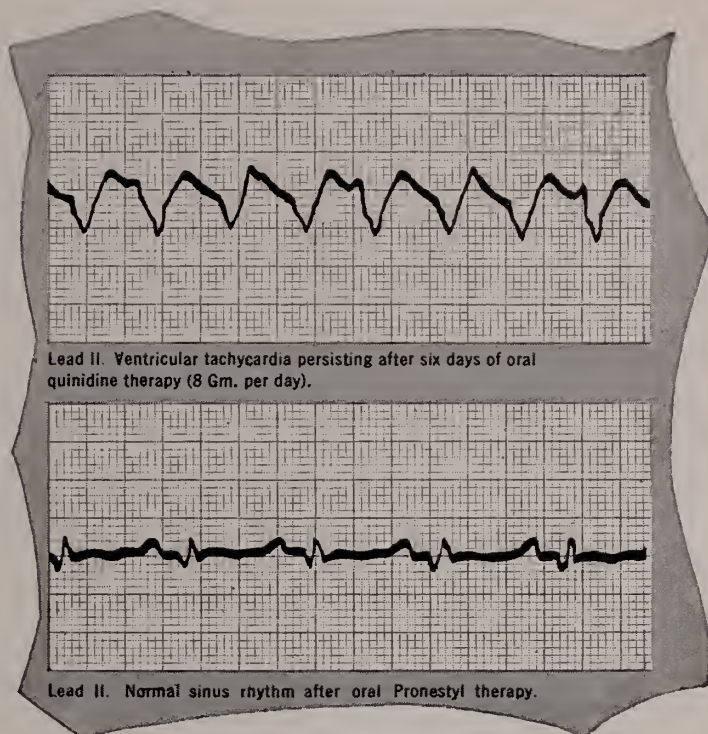
Columbia University announces grant of \$92,000 from the Health Information Foundation for studies on how people spend their money for medical care. Private medical and hospital care costs the American public about eight billion dollars a year or four out of each one hundred dollars spent. No one has yet analyzed the expenditure. Health Information Foundation is a non-profit organization headed by Admiral William H. P. Blandy. Honorary chairman of its advisory committee is Herbert Hoover.

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From The Literature

- Bubert and Cook, Bulletin of School of Medicine, Univ. of Maryland, Vol. 32, pp. 175-190, 1948.
- Paul and Montgomery, J. Iowa State Med. Soc., June, 1948.
- Krantz, Holbert, Iwamoto and Carr, J.A.Ph.A., Vol. 36, pp. 248-250, 1947.
- New and Non-official Remedies, 1950, p. 285.



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Head Pain as a Diagnostic Lead

Frequently the presence of head pain is overlooked. The physician learns of it only if he has made an effort to elicit the information. Since the etiology of the pain is the basis of rational management, the patient should be warned against taking medication before diagnosis is made.

Friedman¹ deplores the tendency to call any chronic recurring headache migraine. Careful history-taking and full physical and neurological examinations are essential for accurate diagnosis. A good starting point is a description of the headache—its character, laterality, frequency and intensity.²

The following chart gives briefly the primary diagnostic leads and treatment for the most common types of headache.

Etiology of Headache	Primary Diagnostic Data	Primary Therapy
Inflammatory e.g., Meningitis Abscess	Inflammation of intracranial structures; fever; leucocytosis; bacteriologic diag.	Specific: sulfonamides and antibiotics. Symptomatic: analgesics.
Tumor	Pain varies as spinal press. changes; skull X-ray.	Specific: surgery. Symptomatic: analgesics &/or hypnotics.
Sinusitis	Sinus congestion and infection; cloudy X-ray.	Specific: antibiotics and drainage. Symptomatic: analgesics.
Hypertensive	Hypertension present but pain not related to b.p. level; Dihydroergotamine relieves pain.	General hypertention therapy; sedation. Symptomatic: analgesics.
Migraine & other vascular headaches	Headache: recurrent, intense, throbbing. No organic causation; migraine in family; patient: energetic, perfectionist. Visual prodromata; g.i. upset during headache.	To abort attack: oral ergotamine plus caffeine. General: adjustment to minimize nervous stress.

Data here tabulated is from: Wolf, G., Jr.,³ and Friedman, A. P.⁴

Cecil⁵ ranks vascular headaches, e.g., migraine and tension headaches, as the most commonly encountered of all. Because of their functional nature and usual recurrence at frequent intervals, they present a long-term therapeutic problem.

Therapy is conducted along two lines:

1) *Psychotherapy to reduce the frequency of attacks. This consists mainly of advice on emotional adjustment to stressful situations and guidance toward a good balance between work and relaxation.*

2) *Treatment of the distressing attack to prevent the usual period of incapacitation. Many investigators have reported that ergotamine preparations are effective for relief of the acute migraine attack in 80% of cases.^{1,6} The drug is given immediately when an attack is approaching and dosage adjusted to the needs of the individual.*

1. Friedman, A. P. and von Storch, T.: 99th A.M.A. Session, June 1950. 2. Butler, S. and Hall, F.: M. Clin. N. Amer., p. 1439 (Sept.) 1949. 3. Wolf, G., Jr.: M. J. 54:25, 1951. 4. Friedman, A. P. and Conn, H. T.: Current Therapy, 1950, p. 563; Saunders Co., Phila. 5. Cecil, R. L.: A Textbook of Medicine, ed. 7, 1948, p. 1483; Saunders Co., Phila. 6. Horton, B. et al: Staff Meet. of Mayo Clinic 20:241, 1945.

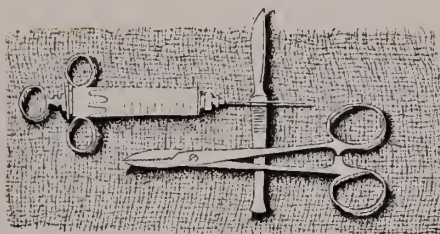
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*Linsell, W. D., and Fletcher, A. P.:
British M. J. 2:1190 (Nov. 25) 1950.

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MAY, 1951

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EDITORIALS

Standardization

WHEN the House of Delegates of the American Medical Association meets in Atlantic City next month it will have before it one of the most perplexing problems it has ever been called upon to solve. This is the matter of hospital standardization.

The term is unfortunate. What has been meant by hospital standardization and what has been carried on so long by the American College of Surgeons is the standardization of professional practice in hospitals. Thus clarified it would seem inconceivable that standardization should be carried on by any group not composed of physicians. In final analysis it seems equally inconceivable that it should be carried on by any other than the only organization which can speak for all of American medicine. That is the American Medical Association.

As far as the physician is concerned the practice of medicine carries certain privileges. With privileges there is always responsibility. So it is with hospital practice. Election to a hospital staff entails privileges, not rights. Responsibility for maintenance of ethical and professional standards is thus indisputably the responsibility of the medical profession.

Many physicians have expressed themselves on this subject. Few, however, have phrased their thoughts more clearly than the group known as the Association of American Physicians and Surgeons.

At a meeting in Chicago, April 21, 1951, they adopted the following resolution:

Whereas, the American Medical Association is the recognized governing body of scientific medicine in the United States, and

Whereas, the maintenance of professional and ethical standards in hospitals must of necessity remain in the hands of the medical profession, and

Whereas, there is danger that responsibility for establishing standards for hospitals may be assumed by the American Hospital Association, a lay organization not bound by the oath and tradition of American medicine, and

Whereas, we recognize a dangerous trend towards lay control over the practice of medicine, and

Whereas, such control entails degradation of the character and quality of medical care, and

Whereas, there can be no division of responsibility in the practice of medicine:

Therefore Be It Resolved, that the Association of American Physicians and Surgeons recommends and urges that the American Medical Association assume full responsibility for the professional and ethical standards in hospitals;

Be It Further Resolved, that a copy of this resolution be sent to each Officer, Trustee and Delegate of the American Medical Association and to all state and county medical societies.

When the House meets in Atlantic City next month it must solve the problem of hospital standardization. It should unhesitatingly accept its responsibility.

The Education Foundation

The American Medical Education Foundation should be supported by every American physician. It should be most actively supported by Northwest physicians for it was first suggested by one of our own members. E. H. McLean, a delegate from Oregon, drafted the resolution which was adopted by the House of Delegates at the Cleveland meeting last December. This was noted in the Oregon section of this journal in the January issue.

More than token support is needed. Many physicians have made substantial personal contributions and many have stimulated nonmedical friends to give. It has been suggested that every physician consider the possibility of giving a hundred dollars a year. This is only a suggestion as contributions must remain a voluntary act. Smaller donations should be sent in if finances of the giver so dictate. It seems little enough, however, when one looks at

the facts of medical school costs. Few of us have ever realized that it cost far more to give us our medical training than we ever paid in tuition or fees. Here is the opportunity to repay something of what we owe.

Indeed, we have already pledged ourselves to repay this debt, for the Oath contains these words:

To hold my teacher in this art equal to my own parents; to make him partner in my livelihood; when he is in need of money to share mine with him.

Idaho Annual Meeting

Annual meeting of the Idaho State Medical Association will be held at Sun Valley June 18-20. First session of the House of Delegates will be held Sunday, June 17.

It has long been the custom of the Idaho Association to make its annual meeting a fine postgraduate session. Year after year these meetings have been interesting and valuable.

Proof of the quality of postgraduate education provided is found in registration figures. Idaho consistently registers a higher percentage of its membership than other Northwest states.

Instructors this year are D. G. Tollefson of Los Angeles, who will present subjects in obstetrics and gynecology; Harry Gordon of Denver, pediatrics;

Curtice Rosser, Dallas, proctology; D. L. C. Bingham, Kingston, Ont., surgery, and G. W. Thorn, Boston, medicine. There will also be a special discussion of the atomic bomb by John Z. Bowers, now of Salt Lake City, recently with the Atomic Energy Commission.

The program this year has been arranged so that all afternoons will be free. This will give time for renewal of friendships, exchange of experiences and enjoyment of the many recreational facilities available at Sun Valley. All Northwest physicians who can do so should plan now to attend this very good meeting. The invitation of Russell Scott, president of the Association, announcement of speakers' subjects and reservation blank will be found on pages 363 to 366.

Research Projects

The new feature found on Page 370 of this issue is much more important than a first cursory glance might indicate. Here is a glimpse of the very heart of medical progress. We advance only as fast as research permits. It is interesting to know what researchers have in mind and to keep informed as to the progress they make. Interesting as such reports may be, however, their publication in *NORTHWEST MEDICINE* has far more significance than mere interest.

In general, it may be said that the medical profession is actually composed of two great groups. One digs up the facts, the other applies them. There are exceptions, to be sure, but not many practising physicians know the technics of scientific investigation and most scientists are like Professor Gottlieb in *Arrowsmith*, magnificent in the laboratory but lost when confronted with bedside illness. Thus the two groups are distinct in function but decidedly interdependent.

The practicing physician must have the fruits of research. The researcher must have the help of the practitioner. It is well known that research work is largely dependent on private gifts and grants. It is probably not quite so well known, or at least not so well recognized, that funds from such sources have been diminishing over recent years. This diminution in giving is partly due to the fact that

those who give do not know what happens to their money. Others who might give are not even aware of the need. Sometimes they do not understand the hours, weeks and years that must be spent on seemingly insignificant phases of research work. They do not realize that a fact, carefully proven and recorded, is a step in the growth of scientific knowledge, even though it has no present discernible application or value. These conditions make it imperative that practicing physicians lend a hand in changing the attitude of the public toward research. Physicians need research, researchers need the help of physicians.

If each practicing physician could interest just one person in position to give toward medical research, the profession and the public would benefit tremendously. If each physician, in his daily contacts, could carry the message of current medical research and its importance to the public, there would be a much better understanding of the meaning of scientific investigation. As an additional reward of no mean proportions there would be a much wider appreciation of the fact that the medical profession is continually striving to advance in order to benefit the public.

These are the reasons that future issues of *NORTHWEST MEDICINE* will carry reports on research projects from time to time.

ORIGINAL ARTICLES

Perspective Concerning Infections in Animals Transmissible to Man*

K. F. MEYER, M.D.**

SAN FRANCISCO

ORGANIZATION OF THE CONFERENCE

IN formally declaring open the Fifth International Northwestern Conference on Diseases of Nature Communicable to Man, I deem it my obligation and privilege to review a few historical highlights of the organization for the benefit of those attending these meetings for the first time.

In July, 1946, in conjunction with the International Great Plains Conference of Entomologists, a group of 12 scientific workers from Alberta, Saskatchewan, British Columbia and the United States met at Waterton Lakes, Glacier Park, Alberta, under the chairmanship of M. R. Bow, Deputy Minister of Health of Canada, for three days to discuss informally their mutual problems relating to arthropod-borne infections transmissible to human beings. Under the title, "Report on the First International Conference on Diseases of Animals Transmissible to Man by Arthropods," Mr. J. H. Brown, Public Health Entomologist, Alberta, prepared in September, 1946, a 35-page report of that first meeting. It is a document full of invaluable information.

A second meeting, generally considered the organizational meeting, was held in August, 1947, at the Rocky Mountain Laboratory of the United States Public Health Service under chairmanship of the late Dr. R. R. Parker. This meeting was again held in conjunction with the Great Plains entomologists. It was organized by Dr. C. B. Philip, who acted as secretary for both groups. Registered attendance was 91 and the "Report" grew to the "Proceedings," with 121 pages of text, charts and tables.

The Third Conference, with an attendance of 25, was held in August, 1948, at the Dominions Laboratory of Hygiene, Kamloops, British Columbia, with Dr. F. A. Humphreys as acting chairman and Mr. Jack Gregson as secretary. A constitution was adopted and purposes of the Conference were defined as a meeting "primarily dealing with the dissemination of information and stimulation or exchange of ideas among workers engaged in studies and control of 'diseases in nature' communicable to

man, and any kindred problems of Western United States and Western Canada." It was recommended that there be no formal membership, and that the number of participants remain small in order to ensure confidential exchange of current field and laboratory data in an atmosphere of kindred understanding. Proceedings of the third meeting cover 119 large mimeographed pages.

This traditional spirit was in part violated by the Fourth Conference, which met on the University of California campus at Berkeley in August, 1949. Acting as chairman for that Conference, I plead guilty of having invited too many speakers and of having offered too many topics for discussion. Temptation to tap the reservoir of diversified knowledge available in the San Francisco Bay Area was too great. Proceedings of last year's Conference, constituting a volume of 262 mimeographed pages, certainly attests that it provides a "concentrated diet of erudition," an expression coined by Past Secretary Dr. C. B. Philip.

I am sure that the 139 members who have read through the pages of the Proceedings have found information and guidance not obtainable from any other source. As a manifestation of confidence in the healthy growth of the Conference meetings, attendance is progressively covering wider and wider geographic ranges. Apparently it fulfills a need in the field of public health which no other group has satisfied.

Again violating tradition, I venture to take a novel step—to review in a formal statement some of the more important newer scientific contributions bearing on the problems to be discussed.

RESERVOIRS

Scattered observations on the search for specific microparasites as the cause of human disease point out again and again that the infective agents living in animal hosts have a striking tendency to cause chronic, latent subclinical infections. In fact, as a source of infection, the clinically diseased mammal or bird plays a role subordinate to the inapparently infected host. This is significantly true for the many species of arthropods that carry and distribute protozoa, microbes and viral agents without showing the least disturbance in their physiologic and procreative functions.

*Read at the Fifth International Northwestern Conference on Diseases of Nature Communicable to Man, Seattle, Wash., August 23, 1950.

**George Williams Hooper Foundation, University of California, San Francisco, Calif.

The members of this Conference are well aware that the spread of a zoonosis or an arthropod-borne infection which they wish to retard or stop is a problem not so much of the overt diseases of nature as of the unrecognized reservoirs. Whenever a micro-parasite with multiple host relationships is discovered, it is reasonable to anticipate that sooner or later it may in some way become involved in human disease. Moreover, the epidemiologic manifestations of the human disease are reflections of the ebb and flow of the infective agent in the extrahuman reservoir. This is particularly true of those that occur sporadically or are arthropod borne. Without comprehensive understanding of the ecology of the animals, birds or arthropods concerned, it is frequently impossible to realize the multiplicity of factors involved. As newer knowledge accrues, the patterns may undergo change in order to remain consistent with the newly acquired facts. New vistas then appear.

What are some of the recent alterations in old epidemiologic patterns? What new inroads have been made?

LOUPING ILL

For over a century, louping ill has afflicted sheep in Scotland and north England. Only in the past two years has there been any reason to believe that human beings ever contract this disease under natural conditions, even though the virus is known to have a broad host infection spectrum. The records of 12 laboratory infections in the United States, Great Britain and Germany did not attract attention until it was demonstrated that the pantropic viral agent of Russian spring and summer (Far Eastern) tick-borne encephalitis is antigenically closely related to the louping-ill virus of sheep.¹ After this knowledge was made available, it is not surprising that at least four human louping-ill infections, probably acquired by contact with sheep, were recently diagnosed in Scotland.² Recent serologic surveys in a slaughterhouse in Scotland brought to light at least three, possibly six, unrecognized infections among a group of thirty-eight employees. Transmission through skin abrasions by contact with infected material or by means of the bite of infected ticks is suspected.

Its clinical characteristics provide louping ill in man with an effective disguise. During the primary phase while the virus is multiplying and circulating in the blood, the infection has influenza-like symp-

toms. Later it may disappear from the blood, but appear again in the central nervous system and spinal fluid, from which it can be readily isolated. If this sequence is followed, symptoms of encephalitis develop. It is not unlikely that many human infections have occurred in Scotland and England, but terminated after the first phase. Thus the diagnostically significant symptoms of encephalitis did not develop.

Not long ago a virus related to the louping-ill virus was isolated from patients with encephalitis and from the tick *Ixodes ricinus* in Czechoslovakia.

INFLUENZA

Some years ago there was some talk of whether swine influenza in the Middle West originally was transferred from human beings to pigs. Now the hypothesis has been reversed: Perhaps a mutant of swine influenza becomes adapted to the human host. In other words, the pig is now open to suspicion as a reservoir. The new thought is that an isolated flare-up of influenza may well reflect a pig-to-man infection chain. This concept received some support through isolation in Korea of the so-called Oti strain of influenza virus. This virus has some serologic relation to the type *A prime* group of influenza viruses. To clarify the issue, at the International Veterinary Congress in London, arrangements were perfected to conduct extensive serologic studies with swine influenza viruses isolated from many countries.

In the meantime, another suggestion that an animal reservoir may play a role in the epidemiology of this scourge received additional support from Anderson in Australia, who incriminates sheep. Preliminary examination of sheep sera obtained shortly after the wave of influenza in Sardinia in 1948 and 1949 have not yielded evidence in support of the sheep influenza virus reservoir idea.³

The underlying ideas of this type of investigation entirely harmonize with Burnet's working hypothesis that many specific human virus diseases originated through transfer to the human host of a microparasite that existed in some animal or arthropod.

INFECTIOUS ABORTION

In fact, every year contributions are made in support of this conclusion. Quite recently a group of French clinicians⁴ made the startling observation that *Vibrio foetus* can cause abortion and possibly some forms of arthritis. Their vivid description of the severe human disease lists severe headache, remittent fever and a fleeting pneumonia, well-marked secondary pneumonia and moderate polymorphonuclear leukocytosis. After an illness lasting for up

1. Edward, D. G. ff.: Immunization against louping ill. Vaccines prepared from chicken embryos. Brit. J. Exper. Path. 29:367-378, 1948.

2. Davison, G. and Neubauer, C.: Meningo-encephalitis in man due to the louping-ill virus. Lancet 2:453-457, Sept. 18, 1948. Brewis, E. G., Neubauer, C. and Hurst, E. W.: Another case of louping ill in man. Isolation of the virus. Lancet 1:689-691, April 23, 1949. Lawson, J. H., Manderson, W. G., and Hurst, E. W.: Louping-ill meningoencephalitis. A further case and a serological survey. Lancet 2:696-699, Oct. 15, 1949.

3. Andrewes, C. H.: Adventures among viruses. II. Epidemic influenza. New England J. Med. 242:197-203, Feb. 9, 1950.

4. Vincent, R., Delarue, J., and Hebert, H.: L'infection placentaire a *Vibrio foetus*. Ann. de med. 51:23-68, 1950.

to four weeks, the symptoms disappear, usually after spontaneous expulsion of the uterine contents. Oddly enough, the infant may survive. The explanation may be that the infection is mainly a placentitis characterized by patchy necrosis combined with infective thrombosis of the arteries supplying the affected cotyledon. Infection clears up rapidly once the placenta is expelled and conception is possible subsequently.

The diagnosis is made by blood culture, the most satisfactory culture medium being citrated meat peptone broth containing 1:1,000 agar. Agglutination tests with agglutinins specific for the particular strain of *Vibrio foetus* in which titers may reach as high as 1:320 likewise aid the diagnosis. Thus it may be worth while to include *Vibrio foetus* agglutination reactions in the routine series of serological tests applied to patients with obscure fevers. A related idea that bears remembering is that thus far at least three strains of distinct antigenic structure have been recognized. Consequently the tests should be performed with several strains.

With regard to treatment, clinical recovery seems to follow administration of penicillin or sulfadiazine and, since the vibrio is quite sensitive to streptomycin in vitro, this antibiotic may prove useful.

How human beings become infected is unknown, but since the human strains are identical with the bovine strains, it is reasonable to suppose that *Vibrio foetus* might gain entrance through dairy products. So far no cases have been reported from the regions in the United States where *Vibrio foetus* infections are relatively common. But this may be because they have not been sought. It might be profitable to find out whether some of the severe illness that defies all attempted exact diagnosis or the 20 per cent of all abortions now relegated to the unexplained category are in some way connected with *Vibrio foetus*.

DISEASE DUE TO CAT SCRATCHES

Another group of French clinicians⁵ report on a disease due to cat scratches (la maladie des griffes du chat) which is apparently not uncommon. At least 20 cases have been encountered in France. Lee Foshay reports that he has seen the infection in the United States. It is essentially a subacute suppurating lymphadenitis affecting inguinal, axillary and epitrochlear nodes. Sometimes several nodes swell to the size of an orange. Although indolent in children, the adenitis may be quite painful and cause a febrile illness with slight leukocytosis in adults and then finally subside by suppuration.

5. Debre, R., Lamy, M., Jammet, L., Costil, L., and Mozziconacci, P.: La maladie des griffes de chat. Bull. et mem. Soc. med. d. hop. de Paris S. 4, 66:76-78, 1950. Paraf, J., and Fournier, E.: Nouveau cas d'adenopathie par griffes du chat. Bull. et mem. Soc. med. d. hop. de Paris S. 4, 66:539, 1950. Weill, J., and Levy, P.: Maladie de la griffure du chat. Bull. et mem. Soc. med. d. hop. de Paris S. 4, 66:967-969.

Inapparent infections recognized by positive skin tests suggest that the exposure occurs oftener than is generally suspected. The infected cat scratches first become a small macule, then a papule and finally a small eschar.

Differential diagnosis has been greatly facilitated by the recognition both by the French workers and by Foshay in Cincinnati that an antigen prepared with the pus, in a manner similar to that in which the Frei reagent is made, elicits a specific intradermal reaction in patients suffering from polylymphadenitis as a result of cat scratches. A specific infective agent has not as yet been isolated but a virus is suspected.

Of interest are the epidemiological facts that presence of cats in the home is essential; in fact, frequency of the disease is entirely in proportion to the number of cats maintained in the household. Children who play with cats a great deal are the most frequent victims. Since the infection is more prevalent in rural than in urban communities, cats are thought to perform the role of an intermediary for the etiologic microparasite. It may have its reservoir in the *Muridae* or birds. Antigens to test this infection may be obtained from Dr. Foshay in Cincinnati.

TRICHINOSIS

Extension of the natural host ranges of any parasite is always of interest. Observations on trichinosis made in Greenland vividly illuminate the complexities and problems of an infection chain when new hosts are suddenly being discovered.⁶ In the spring of 1947, a disease broke out among the native population of northwestern Greenland. It was finally diagnosed as trichinosis, which they apparently contracted by eating walrus (*Odobenus rosmarus*). To ascertain sources and frequency of infection, the health authorities there collected meat samples from different mammals. By the relatively crude "compression slide" technic, 416 samples were examined and 56 were found positive for *Trichina spiralis*. The finding of 46 trichinous sledge dogs among the 66 tested in all probability represents the highest incidence (70 per cent) of this infection ever observed. Next highly infected was the polar bear (6 of 19, or 30 per cent), then the arctic foxes (3 to 101, or 3 per cent).

The finding of a very heavy infestation in a bearded seal (*Erignathus barbatus*) in the extreme north of west Greenland is the first observation of *Trichina spiralis* in a marine mammal. This observation makes it obvious that the walrus can also be infected, though such infection has not yet been proved microscopically.

6. Thorborg, N. B., Tulinius, S., and Roth, H.: Trichinosis in Greenland. Acta path. et microbiol. Scandinav. 25:778-794, 1948.

The probability that trichinosis is widespread in the north polar region has great significance in relation to (1) the ptomaine poisoning that has been reported to occur among Eskimos and (2) polar exploration because of the potential infection of animals used for food. Replenishing food supplies of arctic explorers with fresh meat of polar mammals carries with it an unexpected risk to the health of sledge dogs, an animal indispensable to man in polar regions. During 1949 the occurrence of *Trichinella spiralis* was demonstrated in the Eskimos of Southampton Island and in two dogs and two polar bears (*Thalarctus maritimus*) in the Canadian North.⁷

The parasitologist and the ecologist are confronted with an intriguing problem of tracing the pathway of the trichina through the meat-eating marine animals of the Arctic.

TULAREMIA

While I was visiting the Institut Pasteur, some data about tularemia in Europe were made available to me by Dr. G. Girard. Before 1947 this infection had not been recognized in France. An epizootic among hares (*Lepus europaeus occidentalis*), probably initiated by the importation of *Leporidae* from an infected region in central Europe (Poland and Czechoslovakia) gave rise to the first 20 human cases in France. Surveys have shown that in a single French department, or province (Doubs), over 1,000 animals died from the infection during the early months of 1947. Other regions have now become infected and more than 54 cases of relatively mild tularemia have since been diagnosed in France. Although the described epizootic incident is now over, it is feared that the disease may eventually crop out again. As a curiosity, Dr. Girard mentioned the report of a proved case of tularemia in a hunter who was bitten on the finger by a wild boar while hunting in a region where an epizootic in hares was in progress. He emphasized that in no instance in the cases he has encountered was interhuman infection proved.

There is ample evidence in Austria that two outbreaks were preceded by tularemia of field mice. The first (October, 1936, to May, 1937) involved 200 persons, and the more recent outbreak (November, 1945, to April, 1946) consisted of 139 cases. Infections were, in most cases, contracted directly from the field mice or from apparently secondary but nonetheless important hosts, hares or muskrats.

PSEUDOTUBERCULOSIS

Finally, a conference in Seattle, or in the State of Washington, must be kept abreast of some recent clues in the mysteries of pseudotuberculosis. Of

the four cases of this infection accounted for in the United States,⁸ one was observed in Seattle⁹ and one in Spokane.¹⁰ In neither was the source of infection determined. Two new cases of this rare and uniformly fatal infection have recently been reported from Switzerland.¹¹ There is a report from Czechoslovakia of a case of culturally proved septicemia which subsided under streptomycin treatment.¹² The unfortunate victims in the Swiss cases were men aged 60 and 69, respectively. At autopsy hepatic enlargement and multiple pyelophlebitic abscesses were the relevant pathologic findings. *Pasteurella pseudotuberculosis* was isolated from abscess material.

Of the 17 known cases now on record, all the infections but one were abdominal, a fact which supports the contention that they were acquired via the digestive tract. Two patients had contact with cats or garden soil contaminated with their excreta. Others had eaten rabbits. Although additional sources of *P. pseudotuberculosis* in the animal kingdom have been monkeys (*Erythrocebus patas* and *Papiopapio*),¹³ foxes,¹⁴ lions,¹⁵ turkeys,¹⁶ goats¹⁷ and swine¹⁸ the relationship of these reservoirs to human infection and disease has never been established. An excellent account of *P. pseudotuberculosis* in the cat appeared in a thesis from Alfort.¹⁹ Studies to elucidate the pertinent epidemiologic questions surrounding this apparently rare disease are indicated.

7. Brown, M., Cronk, B., deSinner, F., Green, J. E., Gibbons, J. E., and Kuitunen-Ekbaum, E.: A note on trichinosis in animals of the Canadian Northwest Territories. *Canad. J. Pub. Health* 40:20-21, Jan., 1949. Kuitunen-Ekbaum, E., and Fleming, Z. W.: A note on trichinosis in dogs of the Canadian north. *Canad. J. Pub. Health* 40:514-515, Dec., 1949.

8. Meyer, K. F.: The Pasteurella. In: Bacterial and Mycotic Infections of Man, by Rene Dubos. Philadelphia: J. B. Lippincott Co., 1949, pp. 409-446.

9. Topping, N. H., Watts, C. E., and Lillie, R. D.: A case of human infection with *B. pseudotuberculosis* rodentium. *Pub. Health Rep.* 53:1340-1362, Aug. 5, 1938.

10. Snyder, G. A. C., and Vogel, N. J.: Human infection by *Pasteurella pseudo-tuberculosis*. Report of case with recovery. *Northwest Med.* 42:14-15, Jan., 1943.

11. Hassig, A., Karrer, J., and Dusterla, F.: Ueber Pseudotuberculose beim Menschen. *Schweiz. med. Wchnschr.* 79:971-973, 1949.

12. Burianek, J., Malkova, J., and Tion, F.: Pripad sepse pusobene Pasteurellou pseudotuberculosis. *Casop. lek. cesk.* 88:776-777, 1949. (Abstract: *Bull. Hyg.* 25:75, 1950.)

13. Urbain, A., and Nouvel, J.: Epidemie de pseudotuberculose constatee sur des singes patas *Erythrocebus patas* (Schreber.) *Bull. Acad. nat. med.* 133:299, 1949. Nouvel, J., and Rinjard, J.: Pseudotuberculose du singe cynocephale (*Papio papio* [Desm.]) a bacille de Malassez et Vignal. *Rev. de path. comparee*, p. 60, 1949.

14. Eieland, E.: Norsk. Vet. Tidsskr. 59:1, 1947a.

15. Urbain, J., Nouvel, J., and Bullier, P.: Pseudotuberculose du lion (*Felis leo* L.) *Bull. Acad. vet. franc.* 17:333-336 (Abstract: *Vet. Bull.* 16:96, 1946.)

16. Karlsson, K. E.: Pseudotuberkulos hos honsfaglar. *Skand. Vet. Tidsskr.* 35:673, 1945. Blaxland, J. D.: *Pasteurella pseudotuberculosis* infections in turkeys. *Vet. Rec.* 59:317-318, 1947. (Abstract: *Vet. Bull.* 18:107, 1948.)

17. Indian J. Vet. Sc., 19:34, 1944.

18. Eieland, R.: Tre tilfeller av infeksjon hos gris med *Pasteurella* (Bacterium) pseudotuberculosis rodentium. 59:85-90, 1947b. (Abstract: *Vet. Bull.* 19:594, 1949.)

19. Communal, R.: La pseudotuberculose du chat. Alfort, Thesis, 1945, 125 pp.

Medicine's Problem Child, The Hospital

T. F. LAYE, M.D.

CHICAGO, ILL.

(Continued from April Issue)—CONCLUSION

PASSING from the realm of hospital intramural measures affecting doctors to the realm of possible extramural stabilization measures, one must consider the flanking as well as the direct possibilities inherent in the role of the hospitals' Blue Cross plans and the doctor-sponsored Blue Shield plans where associated.

The Blue Cross plans were established by hospitals largely for the purpose of preventing credit losses, although other minor reasons were contributory. Whether it was in mind at the time or not is immaterial, but, as things have worked out, the presence of the Blue Cross plans has been helpful to hospitals in two additional ways. They have increased hospital utilization, with an accompanying assurance of payment and, by offerings of "medical benefits" and joint administration of some Blue Shield plans, are in a favorable position to exert considerable influence upon the medical profession by the ability to affect the economics of private medical practice.

If doctors have any doubts on the subject, they should take a fresh look at the Blue Cross plans and some of their conduct. Doctors know that the Blue Cross plans are the creations of the hospitals but they may not realize the extent to which they are the complete creatures of the hospitals. It will be pointed out that Blue Cross governing boards are composed of hospital and "public" representatives, plus a small number of physicians selected by Blue Cross boards from names furnished, usually, by regular medical organizations. It will *not* be pointed out that these physicians are but a small minority on such boards and that some such physician Blue Cross board members have testified they are nothing but "medical window dressing for hospital-determined policies."

Doctors know that when first in the field the Blue Cross plans offered coverage against hospital costs only, but today are offering protection against medical costs as well. Few doctors realize that this was first occasioned by the fact that sale of Blue Cross "hospital costs only" contracts soon reached a slow-down point where further expansion became difficult in the absence of a companion contract to cover medical services. This was one reason for Blue Cross encouragement of formation of Blue Shield plans, their willingness to administer them "jointly" and their great concern for offering the public a one-package contract.

All this might be considered seeing an Indian behind every Blue Cross bush were it not for some incautious utterances³ and some recorded Blue Cross performances.

In most parts of the nation the hospitals had comparatively smooth sailing in the introduction of their Blue Cross plans for the reasons that most doctors were unfamiliar with such affairs and incidents which might have alarmed the profession were at a minimum. But in other portions, notably the Pacific Northwest where doctors had long been familiar with prepayment plans, the introduction of Blue Cross plans proved anything but smooth and offered ample food for thought on the true state of affairs.

In that area the medical profession, through its own prepayment plans, had long offered a true one-package medical and hospital contract far more generous than anything offered by a Blue Cross plan. The invasion of the already adequately served field by a Blue Cross plan with a limited contract therefore seemed understandably strange to many doctors. When, additionally, the Blue Cross organization repeatedly attempted to have the existing arrangements upset⁴ and reconstituted under "joint" auspices, naming a deadline for consummation of "joint" arrangements under threat of entering the field of prepaid medical care,⁴ a threat which was later made good while a third set of "negotiations" were in progress,⁵ doctors of the region became convinced the chief concern of the hospitals' Blue Cross is not so much a one-package offering as it is a Blue Cross one-package offering to fit their national pattern and long-range objectives.

More recently there is the fact that Health Service Incorporated, the insurance company wholly owned by the hospitals' Blue Cross and fashioned when it developed a "joint" insurance venture with Blue Shield plans would not be forthcoming, is empowered to underwrite *both* hospital and medical risks, a point which would seem of more than passing significance in light of some of the selected incidents cited above.

Having listed some of the disturbances in factors affecting current doctor-hospital relations, it might be supposed the deterioration may have gone beyond the point of reversal. This may well be true,

3. "Hospitals" (Editorials), 11:73, May, 1937; 11:67, September, 1937.

4. "Northwest Medicine," Vol. 42, No. 12, Page 373, December, 1943.

5. "Northwest Medicine," Vol. 45, No. 8, Page 576, August, 1946.

but it would not seem necessarily so, although the process of restoring harmony will not be simple and may well prove both temper- and time-consuming. One of the most encouraging signs, as evidenced by such things as the Hess report and the more recent alarm occasioned by proposals the American Hospital Association "take over" the hospital standardization program, is that the medical profession may at last be arousing to the point where it is willing to devote some fundamental thought to the subject and to work toward correcting present inequities.

In charting a course among hospitals looking toward improved mutual relations, doctors must not lose sight of certain pertinent facts. They must recognize that today hospitals are no longer the philanthropic bodies of former times; they cannot hope to be, if ever again, until such times as changed tax laws and increased revenues from investments restore a class of citizens able to indulge in philanthropy. Doctors must recognize that the specter of deficits continues to haunt most hospitals. While there may be debate as to what constitutes a deficit, and on the point that what some hospitals call deficits could be avoided if they were content to reduce the scope and grandeur of their activities, there is no denying that hospitals are extremely finance-conscious. Doctors must, therefore, recognize that hospitals have been converted into business institutions and that the compelling force driving governing boards and administrators alike is essentially financial.

Doctors must also recognize that no longer may hospitals be taken for granted as their convenient auxiliaries. Instead, they must recognize that in the thinking prevalent in many hospital circles today the hospitals would become the fountainhead of all health activities in a community, notwithstanding this would effectively destroy the direct patient-doctor responsible relationship which is the basis of all good medical care. Doctors must realize that this thinking, to make the position of the hospital as stable as possible, assumes the extension of the stabilizing process to the ambulatory patient,⁴ therefore beyond hospital walls. They must recognize that in this respect the behavior of Blue Cross, and their own Blue Shield plans where associated, takes on added and grave significance.

Against such a background is there anything which can be done to improve the existing situation? There are a number of things which can be done, but if a lasting solution is desired, the approach must be twofold. Improvement would no doubt follow the removal or correction of certain abuses and irritations which have been permitted to come into the relations of doctors with hospitals. But of more importance is the desirability of re-examining

and re-evaluating the basic principles involved with a view to correcting the fundamental difficulties of which the irritations are but the superficial manifestations.

First fundamental question involves the composition of hospital governing boards. There is little doubt the atmosphere would be more congenial if the organization of hospitals were modified to include *adequate* doctor representation at all times. It is true there is nothing which specifically prevents doctors becoming hospital trustees, but hospital literature^{2,6} has emphasized the fine legal point of whether a physician practicing in a hospital can qualify for board membership because of deriving a profit from his professional work in the hospital. Since a number of well-conducted hospitals do have doctors who function as useful board members, in contradistinction to those who merely supply medical window dressing, the objections to doctor members on governing boards would seem to be more hospital desired and academic than valid. In any selection of doctors for hospital governing boards, however, the medical profession must assume the responsibility for seeing that its members so selected are competent, informed and fearless individuals who will function in the best interest of the public, being particularly alert for anything which might even remotely impair the direct doctor-patient responsible relationship which is the prime factor in good medical care.

A second fundamental involves the matter of standards, particularly as these are concerned with matters affecting medical staffs. There is little doubt the atmosphere would be improved by the removal of certain features of an arbitrary, compulsive nature which have been permitted to develop through interpretation or administration of the hospital standardization program. A number of these which have been mentioned include the following:

Attendance at medical staff meetings should be limited to staff members. Hospital trustees, administrators and subordinates, including ancillary professional employees, should attend only by specific invitation for the sole purpose of supplying data or answering questions, and remain only long enough to discharge that duty. There should be ample time for adequate debate and this should be confined to members of the medical staff.

The number and frequency of staff meetings should be determined by the needs of the staff and not by any hospital or hospital standardization requirement. A quarterly meeting should be the minimum required to maintain any standardization or approval rating. Compulsory attendance at staff meetings should not be required as a means of re-

6. "Measuring the Community for a Hospital," American Hospital Association publication.

taining staff membership; attendance at a county or state medical society meeting should be acceptable in lieu of staff meeting attendance if required. Staff meetings when held should deal solely with the affairs of the hospital concerned and in no sense should be turned into scientific medical society meetings since this is a major function of county and other medical societies.

Original staff appointments should be made by the medical staff, not by the hospital administration with the medical staff acting as a screening agency, and continuance of staff membership should be automatic unless a doctor is removed by the medical staff for cause. Membership in one hospital staff organization should not of itself prejudice a doctor's admissibility to other hospital medical staffs, and some method of reciprocal staff arrangements should be developed in centers having two or more hospitals.

Consideration of these suggestions to overcome irritations arising from operation of the current hospital standardization program indicates the necessity for re-examining the entire relationships involved in the matter. It is also apparent that if the situation is not to get out of hand, with impairment of the essential doctor-patient responsible relationship, any standards of medical care applicable in hospitals must be standards determined and maintained, not by a segment or group of segments of the medical profession, not by hospitals or any organization representing them, but by a mechanism of or representing the *entire* medical profession. To do anything less is to court eventual disaster.

Passing to considerations extending beyond hospital walls and bearing in mind the role which prepayment plans seem destined to play in the future, it is imperative the fundamental structure of the Blue Shield plans, and particularly their relationship with the hospitals' Blue Cross plans, be thoroughly re-examined with a view to having the doctor-sponsored plans sell their own hospitalization program. This will require some expansion or reorganization and possibly additional legislation in a number of instances, and without question will provoke loud protests and numerous pseudo-objections. But, in view of the long-range implications mentioned earlier, it is a step which should not be brushed lightly aside. That it can be done with full fairness to all concerned and in the public interest has been amply demonstrated in California and in the Pacific Northwest. Here, again, to delay may be to court disaster.

Greatest single factor in restoring harmony between doctors and hospitals would be for the hospitals to withdraw from the practice of medicine. In final analysis this is the most aggravated point of current difficulties, yet, because it goes to the

very heart of the problem, it may prove to be the most difficult to adjust. Hospitals engaging in the practice of medicine violate the prime essential of good medical care, the direct doctor-patient responsible relationship. However, it affords hospitals an excellent opportunity to stabilize their financial affairs involving the medical profession, hence the temptation to include medical practice in hospital offerings is understandably attractive to both governing boards and administrators. But for a lasting settlement, the impasse must be solved.

In considering any solution certain other facts must be kept in mind. First of these is that hospitals could not indulge in the practice without the willingness and cooperation of certain members of the medical profession. The second is that, having experienced the financial advantages in offering certain medical services, it is most unlikely hospitals will voluntarily relinquish the advantages. They can be "invited out," but the invitation probably would not be accepted. It would, therefore, seem, if hospitals are to be gotten out of the practice of medicine, they will have to be persuaded out. The form the persuasion must take raises the third fact and *this should be particularly noted*. Hospitals do not have the slightest fear of organized medicine or any of its branches.

The reason for this attitude on the part of hospitals is not difficult to find. Early in the modern doctor-hospital game, hospitals learned that doctors are primarily individualists, natural recipients for a divide-and-conquer technique. They know that much of their present position is due to the assistance afforded them upon occasion by individual doctors and some segments of the profession. They do not recall any effective adverse action initiated by medical organizations of consequence, including the American Medical Association, and are undisturbed by such things as the Hess report and the activities of certain specialty organizations. For they know that such things have succeeded to date only in enhancing the bargaining position of those doctors who have compacts with hospitals or wish to continue dealing with them.

In the face of these facts what choices do doctors have in any efforts put forth to restore doctor-hospital relations to an even keel with no impairment of the essential direct doctor-patient responsible relationship? It would appear they have only three.

The first choice might be to try to ignore the current situation, to leave things much as they are in the hope they may improve. On clear thinking it becomes obvious this is not a choice, but merely a complete surrender to hospital-determined needs and all that would follow.

Doctors, fully aware of the dangers to all involved in socialized medicine, and actively battling the

monster of socialism, have no trouble recognizing a frontal attack, but do seem to have considerable difficulty recognizing infiltration or a flanking movement. Many doctors have observed on the part of a considerable number of hospitals something less than deep-rooted convictions on the subject. The eagerness shown by many hospitals in seeking and accepting "federal" tax funds in their expansion plans, with the "hope" they have not delivered their institutions into the hands of the socializers by so doing, does not give the medical profession much assurance the hospitals could or would prove any more resistant to any future socialistic encroachments. Many doctors have freely voiced the considered opinion that hospital administrations, faced with what they consider continuing deficits, would have little or no hesitancy in placing their institutions in a government socialistic noose, including any doctors so unfortunate as to be subserviently involved with them.

The second choice appears to be to terminate existing arrangements and, starting from the basic position of both doctors and hospitals mentioned earlier, establish a new working arrangement completely fair and equitable to all concerned.

To be successful, such a course will necessitate a change of attitude on the part of certain hospital people. But it will require a much greater alteration in fundamental thinking of the medical profession. It is an easy matter for doctors to place the blame for present unsatisfactory conditions at the doorstep of the hospitals and their organizations. This is unfair to hospitals. These should not be criticized for pursuing their objective, though it be a mistaken, undesirable objective, by all legitimate means and devices at their command, including taking full advantage of any shortcomings or gullibility found in the medical profession. For it is completely clear that the medical profession, having primary responsibility for medical care, at numerous points might have forestalled or prevented many if not all of the developments of which it today complains, if doctors had been alert, unselfish and willing to act.

In effecting any new working relationship between doctors and hospitals, physicians cannot expect to have the job done for them by what has been termed organized medicine. They simply cannot expect local, state or national medical organizations to accomplish something they would like to have done for them, when, as individuals, they are unwilling to do the necessary things for themselves. It is true they might expect the American Medical Association, in view of its public educational campaign exposing the dangers of socialized medicine and socialism, to emphasize the dangers of a flank attack utilizing hospitals. However, there is little in the past or current dealings between the American

Medical Association and hospitals to offer much encouragement in this respect, so it behooves each doctor to recognize the danger signals for himself and act accordingly.

In the current instance, any improvements or corrections in doctor-hospital relations can be expected to result only from activity focused on the point where the fundamental relationship of each doctor and hospital begins, namely, at the point when the doctor first exposes himself on behalf of the patient, to the hospital. Regardless of any ethical, moral or legal considerations involved, it is a fact that hospitals generally have taken full advantage of this initial exposure to drive a hard bargain by laying down a set of conditions they desire shall govern and insisting the doctor shall accept these willy-nilly if his patient is to be admitted and treated by him. Hospitals have generally been adamant on the point, assuming the doctor would capitulate out of immediate regard for the patient.

That doctors are under no legal or moral obligation to accept these promulgations is now beginning to dawn upon many physicians, together with the point that immediate regard for the patient should not be permitted to jeopardize the prime essential of good medical care, the direct patient-doctor responsible relationship. Many doctors now advocating a re-examination of the situation suggest it would be just as logical, and probably more beneficial to patients, for physicians to insist on *their* own set of provisions to govern the doctor-hospital relationship. They point out that the advantage hitherto held by hospitals through admittance is being increasingly nullified by the fact increasing hospital charges tend to price hospitalization out of the market and the fact that more and more doctors are discovering they can practice good medicine without hospitals, with an increased financial return to themselves to offset any added inconvenience.

All the situation would seem to require is a review of relations at the fundamental point of exposure mentioned above. And, since much of the current difficulties have resulted from the hospital medical staff organization and conduct, a keen and *critical analysis of this mechanism is absolutely necessary*. In such an evaluation, each doctor will have to face the question of the primary allegiance of staff members and officers alike and decide which best protects against impairment of good medical care, the hospital and the hospital's medical staff structure with the pressure aberrations to which it is vulnerable, or the profession's own structure based on the cornerstone of the individual doctor and the county medical society. Any new or modified working arrangements resulting can be made completely fair to all concerned.

The third and final choice is for the medical profession itself to assume financial and other responsibility for the operation of the hospital. This is a choice which does not particularly appeal to doctors at this time, but one for which there seems to be an increasing number of advocates. Doctors are aware that doctors have operated and are operating hospitals, both in the small communities and in metropolitan centers, and successfully. Consequently, while it is a choice they do not necessarily seek, it is also one from which they do not shrink.

Today the medical profession is alert to the dangers which confront good medical care in the

existing relations between doctors and hospitals. It likewise possesses a yardstick which enables each doctor to decide for himself if any existing or contemplated condition impairs *or can be developed to impair* the basic essential of good medical care. And since it definitely appears there is nothing wrong with the relationships between doctors and hospitals which doctors can't cure, it remains to be seen if the profession is able and willing to undertake the task of restoring full harmony, or will choose to be overwhelmed by continuous or recurrent stupidity.

THE END

Balanced Supportive Therapy During Anesthesia*

JOHN S. LUNDY, M.D.
ROCHESTER, MINN.

THE problem of supportive therapy during anesthesia and operation varies in direct proportion to the patient's condition before anesthesia and operation as well as during anesthesia and operation. For an elective operation, as a rule, a patient may be gotten into rather good condition before anesthesia and operation by intravenous administration of fluids and by transfusions of blood. It is quite clear now that, because of the blood sub-groups that are recognized, it is desirable to cross-match the blood of the recipient with the blood of the donor. The most important phase of this cross-matching is to determine whether the serum of the recipient will agglutinate the corpuscles of the donor. If this happens, the blood of the donor is particularly dangerous to that particular recipient. If the blood of the patient is group AB, or if he is a so-called universal recipient, and if he receives blood of one or all of the standard groups, this will not change his own blood group. His blood remains in group AB.

Blood for transfusion has become more and more readily available each year. Private blood banks have been organized, and the American Red Cross has supplied blood in many communities. The physician or physicians, therefore, have what is known as a walking blood bank, which has proved to be a very valuable, quick source of blood for emergency and other purposes.

I think it is generally agreed that, if a patient loses blood or is anemic and if his blood pressure falls to a critical level and he shows other signs of shock, the measure of first choice would be transfusion of blood. In the past and especially during World War II, plasma was used as a supportive

measure. It was better than physiologic salt solution or a similar solution containing 5 or 10 per cent dextrose but it was inferior to blood. For some time I have used the following simple method for determining how urgently fluids might be needed during anesthesia and operation. When the value for the systolic blood pressure falls to 85 or 80 mm. of mercury, the intravenous administration of 5 per cent dextrose in water is started. At first, 200 to 250 cc. of the solution is run into the vein rather rapidly, that is, it is administered in a stream rather than by drops. If this does not produce a significant response, for example, an increase of 10 mm. in the value for the systolic blood pressure, blood should be administered immediately. If the rapid injection of 200 to 250 cc. of the solution produces an increase of 10 or 15 mm. in the value for the systolic blood pressure, the administration of the solution is continued at the rate of 75 to 100 drops per minute.

If it is felt that the decrease in the blood pressure was due to traction on the mesentery or on a large joint, or that it was caused by manipulation of the central nervous system, a small dose, for example, 25 to 50 mg., of ephedrine may be administered intravenously. This procedure produces rather good results, which usually are temporary. In some cases, however, it will maintain the blood pressure at a satisfactory level during the remainder of the operation.

In some cases in which a major operation is difficult and of long duration, the administration of relatively large quantities of blood will give the patient just enough support to permit his blood pressure to be maintained at low level but not near enough to normal to make his condition satisfactory. In these cases, the risk to life is very

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*A more extensive bibliography may be found in the following article: Lundy, J. S.: New Solutions. Minnesota Med., 34:21-23, Jan., 1951.

great and the use of measures to increase blood pressure during the critical period seems to offer the best means of combating shock of this type as well as shock of lesser severity.

There is a nameless group of substances that have been used in the treatment of shock. Some are old and some new. I shall mention six of them. The oldest one is a 6 per cent solution of acacia. It was used in World War I by Bayliss. In many cases in which it was used the blood pressure increased and the patient's condition improved greatly. As time went on, it was recognized that storage phenomena occurred in many cases in which this solution was used, especially when it was administered in large quantities. Since it is undesirable for acacia to be stored in the various organs and parts of the body, the use of this material has almost ceased.

Pectin and isinglass have been recommended and tried, but for one reason or another they never have been used extensively.

In World War II, Weese of Germany tried a variety of compounds and finally chose polyvinyl pyrrolidone dissolved in Ringer's solution. This preparation was called periston.¹ It was used by the Wehrmacht in about 100,000 cases during the war but the solution which was used at that time contained only 2.5 per cent of polyvinyl pyrrolidone. Some of this material was captured by American troops. It was tried by them but the results were not considered to be satisfactory. In a personal communication to me, Weese said that a 3.5 per cent solution must be used to produce satisfactory results. I can agree with this. I have used this preparation in 150 to 200 cases and have been able to support blood pressure satisfactorily with quantities as small as 300 cc.

During the time that periston was being developed in Germany, a great deal of work was being done, especially in the United States, in an attempt to develop solutions of gelatin of large molecular size for the same purpose. A 5 per cent solution of gelatin[†] has produced satisfactory results in more than 400 cases of urologic disease.² Transurethral prostatic resection was performed in most of the cases. Molecular weight of the gelatin in the solution was said to be 43,000. An accurate method was used to estimate the amount of blood lost in each case. Our experience in these cases indicated that intravenous administration of 500 cc. of blood and 1,000 cc. of the 5 per cent solution of gelatin would produce satisfactory results in cases in which a liter of blood had been lost. It has not been deter-

mined whether or not storage phenomena occur in cases in which periston or gelatin have been used. I have not observed any untoward effects from the use of these preparations but the number of cases in which I have used periston has been very small.

In 1943 Gruenwall and Ingelman in Sweden began to develop a substance called dextran³ a polysaccharide of large molecular weight, which they proposed to use as a substitute for blood and plasma.⁴ As their work progressed, the results were so encouraging that the Schenley Pharmaceutical Laboratories became interested, and they, in turn, interested me in the use of this material. I began to use it in April, 1946.⁵ I felt that the material was promising and have used it since that time in more than 2,000 cases. It has become clear to me and to some of the surgeons with whom I work that we have been able to treat shock in a number of instances in which the use of blood in relatively large amounts was ineffective. How to explain this phenomenon I am not prepared to say. A few observations that have been made lead me to believe that materials such as I have mentioned in this particular category behave differently than do blood, plasma or solutions of crystalloid materials. Preparations such as dextran, periston and gelatin stay in the circulation for hours or even days. The quantity administered does not have to be very large, as a rule, because, after the preparation has been administered, it seems to continue to circulate in the blood for a considerable period. This circulating volume does seem to be maintained much more effectively than by other materials such as blood, plasma and solutions of sugar and salt.

I have used dextran not only in the treatment of shock but in the prophylaxis of shock. These were cases in which an operation of considerable magnitude was about to begin after anesthesia had been established and exploration had been made. At this stage, 400 to 500 cc. of dextran was administered slowly. I have felt that the patients benefited from its use. There are many cases in which the use of a substance like dextran will be effective. In a case in which blood transfusion is indicated but cannot be used because the group of the patient's blood is not known or blood is not available, a substance like dextran can be administered until blood can be transfused.

It is quite possible that, under such circumstances, one might think of dextran, gelatin and periston as substitutes for blood. I am convinced, however,

[†]The gelatin used in these cases was supplied by The Upjohn Company, Kalamazoo, Michigan.

1. Weese, Hans: Personal communication to the author.

2. Seldon, T. H., Lundy, J. S., Adams, R. C. and Cook, E. N.: Parenteral Administration of Gelatin. Proc. Staff Meet., Mayo Clin., 20:468-469, Nov. 28, 1945.

3. Bull, J. P., Ricketts, C., Squire, J. R., Maycock, W. D'A., Spooner, S. J. L., Mollison, P. L. and Paterson, J. C. S.: Dextran as a Plasma Substitute. *Lancet*, 1:134-143, Jan. 22, 1949.

4. Gruenwall, Anders and Ingelman, Bjoern: Untersuchungen ueber Dextran und sein Verhalten bei parenteraler Zufuhr. 1. Act physiol. Scandinav. 7:97-107, 1944.

5. Lundy, J. S., Gray, H. K. and Craig, W. McK.: Dextran in Supportive Therapy. With Comments on Periston and Gelatin. *Arch. Surg.*, 61:55-60, July, 1950.

that dextran and the other preparations that I have mentioned should not be designated as blood substitutes, because, in cases in which blood is needed, they are not as effective as blood itself, and the term blood substitutes could be misleading to persons who are not familiar with the substances. I am reasonably sure that they should be kept in a category by themselves. Whatever term might be selected to designate this category of preparations, it should clearly indicate that they maintain the circulating volume in the cardiovascular system. Walter Bloom has suggested the term plasma volume expanders.⁶

I am satisfied that, in the last year, I have saved at least six lives with dextran in cases in which administration of considerable quantities of blood proved ineffective. The patients continued to lose ground; the situation became desperate, and

6. Bloom, Walter: Personal communication to the author.

period of survival was estimated to be but a matter of three or four hours. In these cases administration of 400 to 1,000 cc. of a 6 per cent solution of dextran re-established blood pressure and permitted the patient to recover. It is experience of this type that leads me to speak about these substances which can be used as supportive therapy in the course of anesthesia and operation. Obviously, the use of any of these preparations in treatment of shock cannot be 100 per cent effective but I feel that I would not wish to be without them. I now approach a patient who needs supportive treatment with more certainty about beneficial outcome than I did before these preparations were available.

It would seem that these preparations might well serve a very useful purpose in military medicine as well as in civil medicine. They probably would be useful in treating victims of atomic warfare. The term "balanced supportive therapy" is suggested for the use of these preparations.

Therapeutic Management of Congestive Heart Failure

HAROLD H. MCLEMORE, M.D.

SPOKANE, WASH.

TODAY'S trend is toward treating heart failure as a rubber stamp routine. Such practice ignores the importance of individual physiologic responses. Each heart case merits consideration all its own.

DIGITALIS

Clinicians know the romantic story of the discovery of digitalis better than they sometimes grasp the proper use of the drug and its glycosides.¹ The physician should examine carefully the properties of the strophanthin and squill groups as well as digitalis. Hundreds of similar drugs bear varying trade names. No doubt the physician will be served best by choosing one distributed by a reliable manufacturer and sticking to it.

Recently some of the purified glycosides of digitalis have been accepted for use.^{2,3} Crystalline glycosides keep their potency despite adverse storage conditions allowing more accurate dosage than the whole leaf which loses strength in storage. Through smaller bulk and greater potency, coupled with faster gastrointestinal absorption, their full effect may be secured faster with less gastric irritation.

The glycosides possess accumulative traits similar to the whole leaf. They offer a lesser margin of toxic safety but are more rapidly eliminated from the body and are, therefore, advantageous for urgent cases.

Fixation in the protoplasm of the heart seems more prolonged in the use of the purified crystal than with a mixture of glycosides (whole leaf). The calculated dose of purified crystal may be given all at once, provided the patient has not received digitalis previously, invoking a complete response within four to eight hours rather than the 24 to 72 hours required when the dose is divided.

Whole leaf digitalis cannot be administered in the same way because the large amount of nonabsorbable substance usually provokes vomiting. The whole leaf may have an advantage in better cardiotonic response resulting from a synergistic combination of all the glycosides.

Doses of digitalis larger than necessary to benefit the individual not only depress the heart muscle further but may increase the excitability of specialized conducting tissues. This accounts for development of abnormal rhythms. General as well as local signs and symptoms of digitalis toxicity should be recognized and understood. Even the toxic effects of a necessary dose should be considered because favorable circulatory response may be obtained only near the toxic threshold. Toxic manifestations with small doses of digitalis are more likely if the

1. An Account of the Foxglove and Some of Its Medical Uses, With Practical Remarks on Dropsy and Other Disease, Birmingham, England, 1785. (Reprinted in Cardiac Classics: C. V. Mosby, St. Louis, 1941.)

2. Gold, H., Kwit, M. T., Cattell, M. and Travell, J.: Studies on Purified Digitalis Glycosides. IV. The Single Dose Methods of Digitalization, J.A.M.A., 119:928-932, July 18, 1942.

3. Gold, H.: Digitalis and Some of Its Derivatives. Science, 97:125, Feb. 5, 1943; 150, Feb. 12, 1943.

myocardium is damaged severely or undergoes acute toxic or adverse metabolic influences.^{4,5}

Elimination or destruction of digitalis glycosides are greatest shortly after administration or when large amounts are already present. This explains why some patients can tolerate larger maintenance doses than normal after being well digitalized and why cumulative symptoms appear when smaller doses are given over a long period of time.

Digitalis glycosides are not modified or fixed in the blood or lungs after absorption from the gastrointestinal tract or intravenous injection. About 10 per cent of that absorbed or injected is fixed in the heart; the remainder is taken up by skeletal muscles, liver, kidneys and other tissues. The glycosides which enter edema fluid or serous effusions may be fixed to the heart later, causing toxic manifestations following diuresis when the digitalis is released into the vascular bed.⁶

Mainly speaking, digitalis helps only the failing heart. Exceptions may occur in a few of the arrhythmias. Digitalis in well compensated cardiac conditions is not only superfluous but may be harmful. Best results usually are obtained in cases of mitral lesions with congestive failure and auricular fibrillation; good results in cases of aortic stenosis; fair results in hypertensive and coronary heart disease. Cardiovascular syphilis yields poorly to digitalis. Contrary to previous teaching, digitalis may be used successfully in the presence of atrioventricular or bundle branch block accompanied by frank decompensation. Often digitalis not only improves muscular action but by improving coronary circulation lessens the degree of conductive failure.

Using digitalis as a prophylactic for individuals not actually decompensated but with lowered cardiac reserve is still being argued. In the first place, borderline decompensation is hard to classify. Sometimes digitalization as a diagnostic provocative is justified but should be appraised thoughtfully. Cardiac output usually is augmented but a good effect may be neutralized by decrease in circulating blood volume and venous return. Patients with definite cardiac failure often become worse after the use of digitalis. In coronary occlusion, the cardiotonic drugs frequently cause constriction of the coronary arteries.⁷ Circulatory nutrition through the coronary vessels takes place mainly during diastole so anything augmenting the systolic phase is apt to lessen coronary flow. This may explain the appearance of focal necrotic areas in the myocardium, areas reversible if moderate, permanent if severe.

4. Luten, D.: Clinical Studies of Digitalis. II. Toxic Rhythms. With Special Reference to the Similarity Between Such Rhythms in Man and in the Cat. *Arch. Int. Med.*, 35:74-86, Jan., 1925.

6. Miller, G. H.: Demonstration of Digitalis-Like Body in Dropsical Fluids of Patients. *J. Pharmacol. & Exper. Therap.*, 42:264-265, July, 1931.

7. Kisch, B.: Strophanthin Treatment in Angina Pectoris. *Exper. Med. & Surg.*, 3:1-10, Feb., 1945.

The optimum dose is not correlated with any single variable such as body weight. Correct dose varies for different patients and may change at times for the same individual. Rapid or slow digitalization must be decided for each individual. It seems only sensible to attempt rapid digitalization in urgent cases. With most patients, digitalization may be slower, allowing better evaluation of individual sensitivity.

Related glycosides act much as digitalis does. Unless an accumulation of the combined drugs results, first one and then another may be employed. The amounts and characteristics of previous cardiotonic medication must be considered against that to be administered. Failure to take previous digitalization into account can be calamitous.

Failure of digitalis sometimes is hard to explain. Among the reasons for failure may be individual intolerances, acute and chronic myocardial degenerative states, secondary heart influences from avitaminosis and metabolic disturbances, or presence of edema fluid or serous effusions acting as barriers to digitalis fixation. A frequent factor seldom mentioned is diminished circulating blood volume. In the edematous patient, the accumulation of sodium chloride mixed with electrolytic and colloidal by-products of metabolism produces a poverty of circulating proteins and lowers hydrostatic capillary pressure. Osmotic fluid shift is then toward interstitial tissues, lowering blood volume. Digitalis further diminishes this volume. Consequently, although cardiac output may improve, due to better diastolic filling and increased functional capacity, the fluid mobilization remains unchanged.

FLUID BALANCE

Cardiac edema is the result of a complex and altered water metabolism. There can be no doubt that the sodium ion exerts an important influence.⁸ Exactly why is not wholly clear but three important factors play their parts: (1) increased permeability of the capillary membranes, (2) reduction in osmotic pressure of the plasma and, (3) general or local changes in capillary blood pressure.

Normally fluid is forced out of the capillary near the arterial end where blood pressure overbalances colloidal osmotic pressure. At the venous end where blood pressure no longer exceeds osmotic pressure of tissue fluid and plasma proteins, water is taken up. Faulty myocardial function reverses this order. It lowers arterial capillary pressure, reduces blood flow and increases hydrostatic pressure at the venous junction. Equilibrium between the hydrostatic and osmotic pressures of the plasma is disturbed. There follows an outpouring of fluids into the tissues without compensatory reabsorption into the circu-

8. Best, C. H., and Taylor, N. B.: *The Physiological Basis of Medical Practice*, Third Edition, Williams & Wilkins Co., Baltimore, 1943.

lation. With these fluids trickle sodium ions altering the osmotic pressure of the interstitial liquids. Due to increased permeability of the capillary membranes as a result of anoxia, plasma proteins (chiefly the albumin fraction) leak out in increasing quantities. They exert additional osmotic pressure favoring tissue fluids.

Kidney function is altered markedly. There is diminished glomerular filtration causing added retention both of salt and water plus greater loss of plasma proteins. This reduces blood volume and decreases cardiac efficiency.^{9,10}

These dysfunctions indicate that sodium must be restricted. Enough water must be administered to produce an isotonic fluid upon entering the hypertonic interstitial tissues. When this is done blood volume increases. This is the best time for successful use both of digitalis and the mercurial diuretics. Administration of more fluid than necessary is superfluous and may be detrimental. It may only add work for the failing myocardium by increasing blood volume beyond the capacity it can handle efficiently.

Sodium is essential to metabolic welfare because it maintains proper balance between extra and intracellular fluids. When this equilibrium is disturbed by decreased cardiac output with altered renal function, however, fluid retention upsets the physiologic economy of the individual.

The healthy body requires at least two grams of salt a day for maintenance, but can tolerate many times that. Average daily consumption is approximately six to ten grams depending on habits and individual tastes. The latest clinical studies indicate that a limit of two grams or less is necessary to induce proper fluid mobilization in cardiac edema.

By charting fluid intake and output daily for two or three days a fluid exchange pattern may be determined. It should be based on the patient's fluid habits without any coaching. The edematous patient, fearful of aggravating his dropsical condition, takes it on himself to drink only a little water. He rarely uses more than 500 to 800 cc. daily. Urine output decreases in proportion to perhaps 30 per cent of the intake, or 150 to 240 cc.

Although a fluid blueprint is helpful, the physician need not rely on it alone. He can supplement it with laboratory tests such as those for vital capacity, venous pressure, pulse pressure and blood volume (T-1824, Evan's blue dye method.)^{10,11} In addition, he should tabulate weight.

Once the pattern is fixed, parenteral administrations of fluids begin. The first day 1,000 cc. of 5 per cent glucose in distilled water is given (about 50 drops per minute) intravenously. Usually at the end of the first 24 hours, findings are not impressive. Weight has increased, edema is unchanged or is even more evident. Blood volume is not increased and venous pressure, unaltered. During the second 24-hour period, 2,000 cc. of the glucose fluid is used, augmented by ingestion of 1,000 cc. Now administration of 3,000 cc. of water should continue daily—2,000 cc. intravenously and 1,000 cc. by drinking—until the weight chart shows the patient no longer gains during each 24-hour period. When the patient's weight becomes stationary, the physician may assume the tissue fluids have achieved their isotonic equilibrium. With salt restricted, this weight endpoint is reached without alarming changes in the patient's clinical welfare.

Parenteral use of the glucose solution eliminates calculating intestinal absorption. Adding fluids to the circulation increases the cardiac output and, in turn, favors renal circulation. The isotonic glucose dilution aids hypoglycemia resulting from disturbed gluconeogenesis in a sluggish and congested liver. It helps diuresis.

DIURETICS AND DIURESIS

The volume of urine may be increased through renal influence produced by an augmented rate of glomerular filtration and by a reduced rate of tubular reabsorption or both. The xanthines, for example, produce diuresis by increasing glomerular filtration and elevating intraglomerular pressure as well as by an associated increase in the number of functioning glomeruli. They also increase the chloride concentration of the urine and lower the concentration of urea which reduces tubular reabsorption. In a similar fashion ammonium salts act as diuretics.

There are many traditional diuretics including the xanthines—theobromine, caffeine, theocalcin, aminophyllum—and bismuth, sodium tartrate and urea. The actions of some of these last unfortunately are not consistent. Mercurial diuretics also have been popular for centuries although only crude or toxic forms existed. Today relatively non-poisonous compounds have been developed and mercurial diuretics are almost necessary to treat congestive heart failure.

The mercury ion alters the permeability of the cell membrane. In the tubular cells of the kidneys, mercury interferes with the reabsorption of water and sodium chloride. Mercury affects the fluid exchange in other tissues, too, as demonstrated by a dropsical patient who drains only slightly when multiple incisions are made in edematous areas but under the influence of mercury drains more freely.

9. Bridges, W. C., Wheeler, E. O. and White, P. D.: Low Sodium Diet and Free Fluid Intake in the Treatment of Congestive Heart Failure. *New England J. Med.*, 234:573-578, May 2, 1946.

10. Davies, L. J.: Determination of Blood Volume in Man With Evan's Blue ("T-1824"). *Edinburgh M. J.*, 49:465-483, Aug., 1942.

11. Gregersen, M. I.: Practical Method for Determination of Blood Volume With Dye T-1824. *J. Lab. & Clin. Med.*, 29:1266-1285, Dec., 1944.

Mercurphyllum, salyrgan and mercurhydrin are the three common mercurial diuretics. Each contains theophylline which prevents local injection necrosis, increases the rate of mercurial absorption from an intramuscular injection site, prevents storage of mercury and increases the mercurial concentration within the tubules. Despite high mercurial content, none of these drugs appear to damage the kidneys even with prolonged use. They are not entirely without danger. Sudden death is a real, although infrequent possibility, especially when the mercurial diuretic encounters advanced hepatic or renal disease. Occasionally a patient will develop an allergy to the drug with urticarial reactions. Profuse diuresis sometimes will deplete sodium, producing muscle cramps, abdominal colic, nausea and vomiting.

Mercurial diuretics should be avoided in the presence of an appreciable number of red blood cells in the urine. In a sensitization reaction, substituting another mercurial often may solve an allergy although sometimes all diuretics of the same class will induce similar reactions in susceptible persons. Smaller doses than ordinary may be given when there seems a tendency to deplete the patient's sodium or the physician fears redigitalization phenomenon. The smallest effective dose of any diuretic is the proper dose.

Mercurial diuretics may be made up to 20 per cent more effective by giving from six to ten grams of ammonium chloride daily through the mouth. In the presence of adequate liver and kidney functions, the ammonium radical is converted into urea which is diuretic. The remaining acid component acts chiefly on the alkaline sodium bicarbonate of the fixed tissue fluids releasing sodium. Through its affinity for water, sodium is then available for transfer into the bloodstream for urinary elimination. A high acid-ash diet augments this action. As an independent diuretic, however, ammonium chloride is feeble and often brings on gastric irritation. For this reason it seems unwise to give this drug if mercurial diuretics alone will produce satisfactory results.

Another drug sometimes useful with mercurial diuretics is the sodium salt of dehydrocholic acid, administered intravenously in an average dose of two grams. This drug may allow mercurial diuretics to be given patients otherwise too sensitive, permit prolonged use of mercury and encourage smaller doses. The sodium ion contained must be taken into account but the ionizable fraction is so small that it may be discounted for practical purposes.

An important related but often neglected aspect of water balance and diuresis is associated plasma protein deficiency.¹² When other therapy seems unsuccessful, replacing these deficient protein elements in the circulating blood volume either by high pro-

tein diet or parenteral administration of plasma or protein hydrolysates will change the osmotic influences. Gratifying diuresis will result.¹³

It has been argued that, due to loss of valuable body protein, the removal of effusions and edematous fluids from the serous cavities and subcutaneous tissues aggravates a protein-deficient state. Undoubtedly these elements are lost, but they are inaccessible for metabolic usage. By strategic location in the interstitial tissues they cause adverse osmotic influences. A frequent observation that diuresis is successful only after removal of hydropic accumulations supports the opinion expressed here.

An endocrine factor plays a definite role in fluid balance. Through secondary pituitary influence, estrogenic hormones liberate an antidiuretic principle which causes retention of sodium and water. Administration of these hormones may result in reactions that upset an otherwise profitable water balance program and should be avoided whenever practical. When a patient is influenced by narcotics, anaesthetics or an emotional state, the pituitary hormone undoubtedly inhibits water diuresis. This explains the drop in urinary output which sometimes follows depressive doses of morphine or kindred narcotics.

VENESECTION

The dramatic response which frequently comes from venesection makes it occasionally useful in acute cardiac failure. Venesection today deserves more emphasis than it gets. It is most useful in acute pulmonary edema, although not limited entirely to this. Less promising in cases of chronic congestive failure, venesection should be tried only when venous pressure is markedly increased and all other therapeutic means have failed.

The physiologic effect of venesection is to diminish abnormal venous pressure relieving strain on the right side of the heart. Relieving strain reduces pulmonary congestion and increases vital capacity. Reduction of venous pressure is usually transitory. Temporary benefits of venesection may last long enough, however, to permit recovery of the right-side circulation and improve heart response.

DIET

Caloric needs usually are low. For the average individual at bed rest 1,200 calories are adequate. In the severely congested patient even less are satisfactory. The Karrell milk diet often serves admirably during the first few days because it supplies the elements of nutrition in a convenient form

12. Ellis, L. B.: Plasma Protein Deficiency in Patients With Cardiac Edema. *Clin. North America*, 16:942-949, Jan., 1933.

13. Messinger, W. M.: Nitrogen Equilibrium and Serum Protein Regeneration Following Use of Intravenous Amino Acids. *Arch. Int. Med.*, 72:91-103, July, 1943.

most patients will accept. When the acute phase of the illness is past, a change should be made to more conventional and less monotonous foods.

Most of the controversy about diet in cardiovascular diseases revolves about protein requirements. In normal health about 100 grams of protein are required daily for an average individual. In many illnesses, the patient needs more protein to offset a negative nitrogen balance. Protein ordinarily raises metabolism by specific dynamic action with a consequent increase in heart work. This principle applies only when protein is used in oxygenation processes, not when it is retained for structural purposes or as deposit protein.¹⁴

A diet rich in carbohydrate is easily assimilated and produces energy with the least effort. Fat coming from the intestine increases metabolism by its oxidation. Therefore, only enough to make the other foods more palatable should be permitted.

OXYGEN

Even though anoxemia may be mild, administering oxygen has definite value in congestive heart failure. Increased oxygen tension in the coronary arteries creates a direct and specific beneficial effect on the myocardium. It is not always judicious, however, to give oxygen as part of a routine. Temperament and disposition of the individual must be considered. In cyanosis and severe dyspnea, oxygen may be an absolute and life-saving necessity. It is not always wise to wait for signs of cyanosis; they are variable and may be misinterpreted. Non-exertional dyspnea indicates the degree of oxygen deficiency and is enough evidence that anoxemia exists.

Oxygen not only improves myocardial efficiency by increased pressure in the arterial blood; it reduces shallow breathing and excessive carbon dioxide loss. Hemoglobin gives up its oxygen less readily at low carbon dioxide tensions. In some cases administering an oxygen-carbon dioxide mixture has proven useful.

In severely decompensated persons with pulmonary edema, oxygen obviously must be employed under increased tension. The B.L.B. mask will administer 70 to 100 per cent oxygen, nasal catheter about 60 per cent, but the oxygen tent, only 20 to 30 per cent. Because 100 per cent oxygen irritates the respiratory tract, it should not be used more than 48 hours and this should be broken.

BED REST

Enforced physical activity is a time-honored but abused rule of thumb. Phlebothrombosis and its complications are commoner among hospitalized cardinals than any other group.¹⁵ The etiologic explana-

tion fails to incriminate intramural thrombus as has been done in the past. Phlebothrombosis is believed to arise in the lower extremities. This is not illogical when one considers retarded venous circulation, anoxic capillary epithelial damage and a tendency to erythrocytic roulette formation when oxygen tension is low. Enforced inactivity lessens muscle tone and decreases normal pumping action. Suspected shortening of clotting time by digitalis is another reason to consider the high incidence of embolic complications. The psychogenic element of monotonous inactivity if prolonged unnecessarily may make cardiac neurosis outrun the original illness.

In the initial phases of cardiac decompensation, rest alone may build a cardiac reserve sufficient to permit eventual resumption of restricted activities. A regimen of rest does not necessarily mean foregoing every slight activity. There is sometimes less effort in using a bedside toilet than wrestling and grunting on a bedpan. Even then, ordinary restless movements of the lower extremities should not be discouraged. Experience shows that dyspnea is a useful barometer. If the patient can be taught to limit his activities to just below the threshold of distress he rarely will deplete his cardiac reserve.

When compensation restored, the task has not been completed. Guiding rehabilitation offers an even greater challenge to professional ability. The patient's future should be directed toward avoiding any situation that might bring on another myocardial breakdown. The patient must be impressed with his responsibility to himself and to society so he will not disintegrate to an elementary and invalidated existence.

SUMMARY AND CONCLUSIONS

1. Therapeutic aspects of congestive heart failure necessitate a consideration of factors beyond those required to rehabilitate a failing myocardium. Of equal importance are measures directed toward correcting altered physiological responses to disturbed cellular metabolism of the whole body.

2. The patient suffering from congestive heart failure is an individual requiring medical management for an individual.

3. Cardiac edema is the result of a complex and altered water metabolism. It involves a deranged physiologic state which affects the sensitive equilibrium between hydrostatic and osmotic pressures of blood plasma and interstitial tissue fluids. Successful therapy can be accomplished only by restoring necessary balance.

4. Because the fluids of cardiac edema are hypertonic solutions, they must be diluted to permit osmotic flow in direction of the vascular bed. The amount of water necessary to guide this osmotic flow is variable; too much water is not only super-

14. Madden, S. C. and Whipple, G. H.: Plasma Proteins, Their Source, Production and Utilization. *Physiol. Rev.*, 20:194-217, April, 1940.

15. Dock, William: Evil Sequelae of Recumbency in Treatment of Heart Disease. *J.A.M.A.*, 125:1083-1085, Aug. 19, 1944.

fluous but may lead to breakdown of the whole system.

5. Effectiveness of digitalis (aside from improved myocardial efficiency) and the diuretics which permit discharge of the load of fluid from tissues through the kidneys, is dependent on a reversal of the adverse osmotic flow.

6. The diet of a cardiac patient with edema should contain adequate food elements of basal caloric amount low in sodium ion content. The protein provided must be sufficient to sustain positive nitrogen balance and to replace deficient stores without invoking increased metabolism.

7. The presence of non-exertional dyspnea is ample evidence that anoxemia exists. Its extent is roughly proportionate to the degree of oxygen deficiency. The method by which oxygen is best employed depends upon individual requirements in respect to the degree of edematous barrier within the pulmonary alveoli.

8. Enforced bed rest in cardiac disease cannot be employed as a rule of thumb because each individual requires his own yardstick. The symptom of dyspnea is a useful barometer indicating the degree of physical effort that can be allowed without provoking myocardial distress.

Murine (Endemic) Typhus in Oregon

JAMES H. GEROW, M.D., GUY MOUNT, M.D.

OREGON CITY, ORE.

AND LYNN WOLFE, B.S.

PORTLAND, ORE.

THE following case report of probable Murine or Endemic Typhus is believed to be the first reported in Oregon:

Mr. W. G., a fifty-year-old white farmer, was hospitalized November 23, 1950, complaining of progressive weakness and erythema of face and trunk. The patient was last perfectly well November 11, 1950, when he experienced sore throat and ear sickness. Between this date and hospital admission he noted chills, fever, increasing fatigue, constipation and rectal tenesmus.

Physical examination: Face erythematous, normal fundi, marked conjunctivitis, and moderate purulent discharge from eyes, no palpable lymphadenopathy; a diffuse, macular erythematous rash of dull red color over chest, periumbilical area and flanks which blanched on pressure, was non-puritic and non-tender. The macules were approximately five millimeters in diameter, some discrete, but, most confluent. Cardio-respiratory, abdominal and neurological examinations were normal. Temperature was 101.0 F., pulse 120, blood pressure 98/78 on admission.

Laboratory findings: Urine—specific gravity varied 1.008 to 1.027, albumin three-plus once, negative sugar, microscopically 18-20 granular casts, 4-6 WBC. Urine cleared by December 4. Blood examination disclosed: RBC 5.5 million, hemoglobin 109, WBC 37,950, differential 92 neutrophils (28 stab. form), 5 lymphocytes, 2 monos, 1 eosinophil, Kahn negative. On November 27, BUN was 28, alkali reserve 22.4 mg. per cent, total serum protein 5.2 grams.

Agglutination tests were negative for *E. typhi*, *salmonella paratyphi* and *schottmuelleri* and for brucella; positive for *B. proteus* strains in the following dilutions: OX-19, 1:640; OX-2, 1:20; OX-K, 1:320. Clinical course was stormy. The patient was nervous, profusely diaphoretic and developed "pain all over," vomited large amounts of brownish fluid, became irrational and was momentarily unconscious in the first 24-hour period. From November 28 to December 3, the patient was incontinent, had momentary periods of lucidity and was maintained on parenteral glucose, saline and two whole blood transfusions. The patient was mentally alert on December 3, and from then until his discharge on December 19, his recovery was uneventful. The temperature curve showed a daily dicrotic spiking and fall by lysis, the pulse showing a lag period of several hours in its spike. The rash spread to include the axillae and antecubital fossae, became progressively brown and indistinct and had disappeared entirely by discharge.

PURPOSE OF THIS REPORT

This case is presented for the express purpose of stimulating further interest and earlier recognition of similar cases: admitting the paucity of laboratory studies with the recommendation that such determinations as: complement-fixation, specific agglutination for *Rickettsiae*, biopsy of skin lesions, guinea-pig inoculation, and especially repeated Weil-Felix determinations by a competent laboratory be accomplished during the active course of the disease.



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STATE SECTIONS

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PORTLAND, OCT. 10-13, 1951**

President, W. J. Weese, M.D., Ontario

Secretary, R. F. Miller, M.D., Portland

Executive Secretary, Mr. C. C. Foley, Portland

Opinions, Views or Comments presented in articles appearing in this section are those of the individual authors and are not necessarily those of Oregon State Medical Society.

Requests for Approval

This writer has long cast a dubious and critical eye, and has frequently so stated, upon requests to medical societies, particularly the Oregon State Medical Society and its Council, for approval of various and sundry projects or desires.

Perhaps it would be more correct to say it is the requests for "quick" approval which touch a sensitive spot, for on many occasions in the past he has seen a so-called "worthy motive" project given quick approval, only to have the fact of this approval flare up under later circumstances to embarrass or occasionally plague the approving medical organization, and by extension the entire medical profession.

We doctors should realize, once and for all, that when some idea, plan, project or what have you is presented to a branch of organized medicine for approval, it is done for one reason and for one reason only. It is solely to make the job of the sponsors easier in dealing with those they wish to impress favorably with their idea, plan, project or what have you. The reasoning behind this should be obvious to every thinking doctor, based as it is on the esteem in which the medical profession has long been held. To give an approval, quick or otherwise, to a request which has not been studied, is not conducive to maintaining this esteem at a high level.

This is not to say that approval should not be given to worth-while requests. The profession would be derelict in its duty to the public if it did not do so in merited instances. But it should follow certain hard and fast rules in the matter of granting approval requests, whether such requests come from fellow members of the medical profession or from lay sources.

A sound procedure would be for all approval requests to be referred to a suitable committee for study, with a recommendation for or against approval to be forthcoming at a later date. If the applicants for approval object to this procedure or if there is a time factor involved which seems not to afford sufficient time for adequate study, then it is safe to assume the request should be rejected forthwith.

The suggestion has been made that any approvals given should be limited and not continuing and should automatically expire with either the calendar or medical society year. This would work no hardship upon genuinely worthy projects, and would have the additional benefit of encouraging any doubtful ones to stay within the bounds of public interest. The suggestion could well be looked into.

GORDON LEITCH

Oregon Gets Compared

A "Report on the National Cancer Institute," by George F. Connery, editor of the American Medical Association *Washington News Service*, mentions Oregon in two illustrative comparisons.

Under the heading "Research Branch," it is pointed out in connection with grants and fellowships that "Cancer research funds, like all those awarded for research by the Public Health Service, are not distributed geographically or by population.

"As an example, institutions in one state (New York) in 1950 received \$579,632 or 20.4 per cent of the research grant money appropriated in one year, whereas another (Oregon) received only \$5,400 or 0.2 per cent of the total. These figures reflect the situation in each state. Oregon had only one research application and it was granted in full. New Yorkers

asked for considerably more but not all was granted. The number and dollar value of research grants is said to be in fairly close proportion to the total requested, from state to state, and to the research potential of a region."

Again, in the matter of "Cancer Control Branch," handled through state boards of health, the report has this to say:

"Under the law, the maximum a state health department may receive is established by the population-income-cancer incidence formula, which makes more money available per capita to relatively poor states. The same two states—New York and Oregon—are just as effective examples of what happens when cancer control funds are passed out. New York's population is about ten times that of Oregon, yet it received 100

times as much money for cancer research grants. But for control work, New York got only eight and one-half times as much money as Oregon, which meant that the federal government actually was spending more money per capita to help control cancer in Oregon than it was in New York."

Supreme Court to Review Case

Announcement was made on April 9 that the U. S. Supreme Court had decided to accept for review the case of United States vs. Oregon State Medical Society et al.

Notice of appeal, from the decision rendered by U. S. District Judge Claude McCulloch in the fall of 1950, was filed by government attorneys at the turn of the year in the suit brought by the Department of Justice against Oregon State Medical Society, eight county societies and eight individual physicians.

The supreme court might have declined to accept the case for review, in which case the decision in favor of the defendants handed down by Judge McCulloch would have stood as final.

In agreeing to accept the case the supreme court will now review the record as established in Judge McCulloch's court. It is anticipated the study of the record will require several months which, with the usual summer recess of the court, indicates a decision will probably not be forthcoming before October or November of this year.

Pete the Pest Says

Practical Politics: Several prominent Portland doctors, the kind the laity call "big shots," received liberal education in the ways of politicians during early April encounter with prominent legislator.

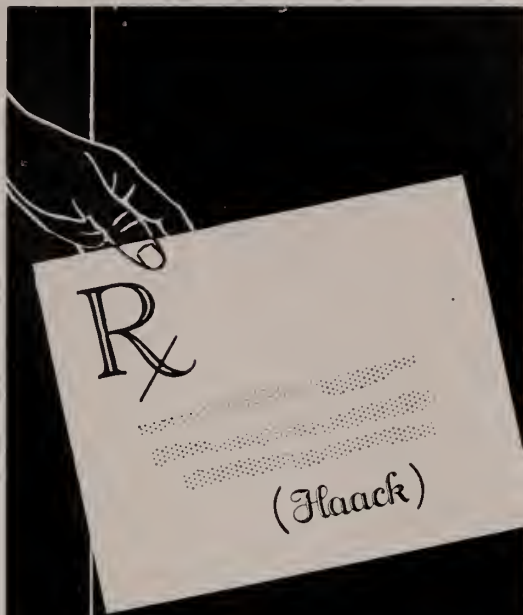
Prominent Portland physician, wishing to be helpful in presenting facts on medical legislation to law makers, called chairman of important legislative committee to offer help. After a considerable tirade about doctors and legislators, how things should be done and so on, politician accepted invitation to meet with P.P.P. for dinner in Salem the same evening.

P.P.P. and his friends journeyed to Salem, did best to contact law maker. But despite best evening-long efforts of himself, hotel employees and legislators, failed to raise his dinner date. About midnight (after an enjoyable evening spent with some legislative pals of missing legislator) Portland medicos decided they were wasting time, left for home.

Question is now being asked: At next election who will vote for whom?

Keeping Record Straight: Enthusiastic supporters and publicists for H.B. 670, the bill to appropriate Four Million shekels for teaching hospital at U. of O. Medical School, have made great point the project was and is approved by Oregon State Medical Society. Usual statement runs something like one appearing in Alumni Association letter sent to all U. of O. medical graduates: "The Oregon State Medical Society has sent out resolutions approving the TEACHING HOSPITAL. . . ."

On reading such letter shown him by colleague, Portland medico with sad previous experience with such venture decided to do little checking up. Found



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state society had not sent out any resolutions on subject. Also found only pertinent state society resolutions called for approval of teaching hospital *at indigent level*. Did find Multnomah County Medical Society passed resolution favoring hospital without qualifying phrase used by state society.

"Garbling" of approval (word this ordinarily mild-mannered doc used was much stronger) so upset medico he quietly called a number of his influential legislative friends to give them facts, adding his private opinion of how state could save money at this time.

Medical friends figured this activity would afford safety valve for their colleague's feelings. Now they are surprised to find the old boy wondering if some of his patients, long referred to enthusiastic teaching hospital supporter consultants, are getting the same careful treatment the state society resolution got.

Obituaries

DR. JOHN S. BISHOP, 91, former homeopathic practitioner of Astoria and Forest Grove, died in late March in Portland after a considerable illness. Born in the Hawaiian Islands, he was a graduate of the University of California and Boston Medical School. In early years he practiced in Michigan and Massachusetts, later removing to practice in Portland and Astoria. Following the death of his wife in 1937 he retired from practice and lived his remaining years in Portland.

Woman's Auxiliary

The 24th Annual Session of the Woman's Auxiliary to the Oregon State Medical Society was held April 28, at the Hotel Benson, Portland. Mrs. Leon Goldsmith, Portland, presiding president, gave a summary of Auxiliary activities for the year, followed by annual reports of officers, committee chairmen and county Auxiliary presidents.

The election of officers for the year 1951-1952 was conducted during the afternoon session, following which was installation. Mrs. W. W. Baum, Salem, was installed as president of the Auxiliary, having been elected president-elect at the 1950 session. Other officers were: Mrs. J. B. Springer, Portland, president-elect; Mrs. John G. Manning, McMinnville, first vice-president; Mrs. William J. Moore, Grants Pass, second vice-president; Mrs. Leonard D. Jacobson, Eugene, third vice-president; Mrs. Oscar Stenberg, Hood River, fourth vice-president; Mrs. Harold E. Davis, Portland, recording secretary; Mrs. Richard H. Upjohn, Salem, corresponding secretary; Mrs. L. Lloyd Smith, Oregon City, treasurer, and Mrs. G. C. Bellinger, Salem, auditor.

Elected as directors to serve a two-year term, expiring in 1953, were Mrs. Frank E. Fowler, Astoria, and Mrs. Leon A. Goldsmith, Portland. Mrs. Goldsmith is the immediate past president.

Society Meetings

Annual meeting of the Eastern Oregon District Society will be held at La Grande June 15 and 16. Edwin G. Kirby, La Grande, is president of the society; B. R. Shauuff, Enterprise, vice-president, and Warren H. Alden, John Day, secretary-treasurer. This society is composed of the physicians of Morrow, Umatilla, Union, Wallowa, Grant, Baker, Harney and Malheur Counties.

The program will feature discussion by the following physicians of Portland: Leon F. Ray, dermatology; Werner E. Zeller, surgery; Allan M. Boyden, surgery; E. G. Chuinard, orthopedics; John F. Larsell, urology; Walter A. Goss, Jr., pediatrics; Melvin W. Breese, obstetrics; John W. Welch and Robert J. Condon, alcoholism; Marvin Swartz, cardiology, and Edward W. Abrams, Spokane, internal medicine.

Members of the society will also hear two surgeons who are participating in the extramural postgraduate lecture series on cancer: Ernest M. Daland, Harvard Medical School, Boston, and Langdon Parsons, Boston University School of Medicine. The series is sponsored jointly by the Oregon State Medical Society and the Oregon State Board of Health.

There will be a banquet Friday evening, and the annual business meeting Saturday noon will include election of officers.

The Women's Auxiliary will have a luncheon meeting on Friday, followed by a fashion show.

Personals

DEAN B. SEABROOK, Portland, has been appointed a member of the Oregon State Advisory Committee on Selective Service. Dr. Seabrook replaces Dean P. Crowell, who now resides in California. Dr. Crowell submitted his resignation earlier in the year. The committee has the responsibility of coordinating military and civilian efforts in utilization of medical personnel. Ernest L. Boylen, Portland, is chairman of the committee, and Harry C. Blair, Portland, is the third member. The committee confers regularly with the State Director of Selective Service.

EMIL D. FURRER, Eugene, was named president-elect of the Pacific Northwest Society of Pathologists at a joint session with the Northwest regional meeting of the College of American Pathologists held early in April. Dr. Furrer succeeds C. P. Larson, Tacoma. Other officers elected to serve for the ensuing year were: H. K. Fidler, Vancouver, B. C., vice-president, and George A. C. Snyder, Portland, secretary-treasurer.

THEODORE J. PASQUESI, Portland, was selected by the Council of the Oregon State Medical Society for election to the Oregon Physicians' Service Board of Trustees to fill the unexpired term made vacant by the death of R. H. Swinney. The term ends in 1952. Dr. Pasquesi's name will be submitted to the O. P. S. Board of Directors at their next annual meeting.

New staff appointments to the Oregon Physicians' Service are announced as follows: Theodore W.



Adams, Portland, obstetrics and gynecology; Arthur W. Berg, Oregon City, diagnosis and internal medicine; L. Allen Gay, The Dalles, radiology; James M. Whitely, Portland, obstetrics and gynecology; John W. Ritchie, Eugene, surgery, and Paul F. Wilson, Mapleton, Oregon, general staff.

More than two hundred University of Oregon Medical School alumni registered for the 36th annual meeting held at the school on April 25-27. The program consisted of lectures and panel discussions, highlighted by Sommer Memorial lecturers, including

Hans Chiari, Vienna, Austria; Albert H. Lyons, New York, and Cranston W. Holman, New York City.

Roderick E. Begg, Portland, was elected alumni president, succeeding Homer P. Rush, Portland. Other officers elected were: Dean B. Seabrook, Portland, secretary; W. Rich Warrington, Portland, treasurer; Merle Manguson, Portland, first vice-president. Other vice-presidents elected were: Harold Dedman, Boise; Harold Nichols, Seattle; Dwight H. Findlay, Medford, and Charles A. Preuss, Santa Barbara, California.

The annual banquet was attended by 160 alumni and their wives. A luncheon at the University Club on Tuesday was also given in honor of the wives.

State Board of Medical Examiners

George H. Lage of Portland has been elected president of the Oregon State Board of Medical Examiners. Wilmot C. Foster, Portland, was re-elected secretary-treasurer.

The following physicians have been licensed to practice medicine and surgery in the state:

John W. Bishop, Eugene; Darius F. Caffaratti, location undecided; D. W. Clouser, Jerome Goldman, Benjamin E. Herndon, David B. Hinshaw and Harry E. Sprang, all to locate in Portland; Eugene A. Hahn, Amity, and J. W. Jansonius and Sidney C. Stenerodden, location undecided.

The regular semi-annual State Board examinations for Oregon will be held June 21-23. Announcement of early dates has been made to accommodate applicants who are anticipating call to active duty in the armed forces on or before July 1. Licenses will not be issued until the July meeting of the Board, scheduled for July 27 and 28.

Applicants for the examination must qualify as follows: Completion of twelve months approved internship; completion of nine months approved internship, plus three months service in an approved hospital; or

completion of nine months approved internship plus three months service as a commissioned officer in the medical corps of a branch of the armed forces.

Applications should be submitted with all supporting documents to the Board of Examiners before June 1. Application forms with general instructions may be obtained from the Oregon State Board of Medical Examiners, 609 Failing Building, Portland 5, Oregon.

Schedule for examinations is as follows:

Thursday, June 21

9:00 a. m.—Chemistry and Toxicology
10:30 a. m.—Diagnosis
1:30 p. m.—Hygiene and Public Health
3:00 p. m.—Pathology

Friday, June 22

9:00 a. m.—Practice of Medicine
10:35 a. m.—Anatomy
1:30 p. m.—Bacteriology
3:00 p. m.—Pediatrics

Saturday, June 23

9:00 a. m.—Obstetrics and Gynecology
10:30 a. m.—Surgery
1:30 p. m.—Materia Medica and Therapeutics
3:00 p. m.—Physiology and Histology

Special Disability Insurance Plan

Insured members of the Society's Disability Insurance Program who are in active practice and under 60 years of age may apply for increased benefits as announced until May 15. All applications will be made effective, regardless of physical history. The increased benefits were made effective on May 1.

This insurance plan is underwritten by the Metropolitan Casualty Insurance Company of New York. The company has agreed to a new maximum indemnity increase from \$50.00 to \$75.00 per week. In addition to the new increased benefits, the company is broadening all present and future policies to provide waiver of premium; elective indemnity for certain

specified accidents; and payment of weekly indemnity in addition to dismemberment benefits.

Benefits of the Disability Plan, which has been in operation since 1944, include accident indemnity; sickness indemnity payable from the eighth day of disability or the first day of hospital confinement, whichever occurs first, up to 52 weeks; individual policies non-cancellable to age 70, subject to membership in the Society, active practice and continuance of this plan for all members; house confinement not required during any period of disability.

It is estimated that premiums quoted under this plan are 40 per cent less than the cost of similar coverage available on an individual basis.

University of Oregon Medical School

Allan J. Hill, Jr., has been appointed head of the department of pediatrics at the medical school and chief of staff of Doernbecher Children's Hospital. Dr. Hill is a graduate of the University of Minnesota Medical School and has held appointments to the visiting staffs at Charity Hospital in New Orleans, Bobs Roberts Memorial Hospital, Chicago, and Northwestern Hospital at Minneapolis. Before coming to Oregon, Dr. Hill was in private practice in Minneapolis and was clinical assistant professor at the University of Minnesota Medical School.

New assistant medical director of the University of Oregon Medical School Hospitals and Clinics is R. Jarvis Gould. Dr. Gould is a graduate of the University of Oregon Medical School. After serving three years in the army medical corps, he was appointed assistant chief of medical service at the Veterans Hospital in Portland and was a clinical instructor at the medical school. Dr. Gould is also assistant professor of medicine at the school.

Harry E. Spring has been appointed instructor in child psychiatry at the medical school. He is a graduate of the Ohio State Medical School and completed his residency in psychiatry at Winter General Veterans Administration Hospital, Topeka. After completing his residency, he accepted an appointment as a Fellow in the Menninger Foundation School of Psychiatry, which position he held until assuming his duties here.

Mr. J. J. Adams has been appointed director of information at the medical school. Adams graduated from Gonzaga University in Spokane and served as assistant director of public relations at that institution until accepting his new position in Oregon. He will also act as public relations consultant and executive secretary to the Alumni Association.

Postgraduate sessions at the University of Oregon Medical School have included courses in obstetrics, general surgery, internal medicine and ophthalmology and otolaryngology. Guest speakers for the meeting of Oregon Academy of Ophthalmology and Otolaryngology included Bruce Fralich from the University of Michigan Medical School; Richard Scobee and Theodore Walsh, Washington University, and Maurice Cottle from the University of Chicago Medical School. This session was attended by 125 physicians from all over the Northwest. A five-day course in electrocardiography will be given June 11-15 at the medical school.

T. T. Hutchens of the department of biochemistry has received a one-year postdoctorate research fellowship from the National Institute of Health. Dr. Hutchens, who has recently returned from a two-week course in the use of radio-isotopes in medicine at the Oak Ridge Institute of Nuclear Studies, Oak

Ridge, Tennessee, will spend his time studying the metabolism of cholesterol in the radio-isotope laboratory at the medical school.

Warren C. Hunter, professor and head of the department of pathology, has been appointed acting director of the State Crime Detection Laboratory at the medical school. Homer H. Harris will become director of the crime laboratory July 1. He is currently studying forensic medicine and crime investigation under Thomas A. Gonzales, chief medical examiner of New York City.

As We Go to Press—

BY WESTERN UNION

NORTHWEST MEDICINE

1951 MAY 3 PM 2 28

309 DOUGLAS BUILDING

SEATTLE, WASHINGTON

OREGON STATE LEGISLATURE APPROVED FOUR MILLION DOLLARS FOR TEACHING HOSPITAL ON CAMPUS AT UNIVERSITY OF OREGON MEDICAL SCHOOL AT PORTLAND SENATE PASSED BILL WITH UNANIMOUS VOTE THIS AFTERNOON. BILL NOW AWAITS GOVERNORS SIGNATURE.

J. J. ADAMS

DIRECTOR OF INFORMATION

UNIVERSITY OF OREGON MEDICAL SCHOOL

Proposed Teaching Hospital

The \$4,000,000 request for the construction of a teaching hospital at the University of Oregon Medical School in Portland is now before the Senate. The request was included in capital outlay requests of the State Board of Higher Education submitted for consideration to the 1951 Legislature. The request has been processed through the Ways and Means Committee, the Tax Committee and has been passed and approved by the House of Representatives.

Approximately two million dollars of the estimated six million dollars necessary for the teaching hospital is now on hand. A vote of the people in 1945 provided for a portion of the funds now on hand, and the 1949 Legislature made available \$1,660,000.

As now planned, the hospital will have approximately 350 beds, 225 of which will be for adults and 125 for children. The children's section will replace the present Doernbecher Hospital, which will be remodeled to be used as additional facilities for the outpatient clinic. The teaching hospital will enable, it is estimated, an increase in the enrollment of the medical school from the present 75 students to 90 students, a 20 per cent increase in student capacity.

Should this request be duly approved by the Senate, it will then go on for the Governor's signature. Detailed plans for the teaching hospital will then be completed, and construction will probably begin next spring.

WASHINGTON STATE MEDICAL ASSOCIATION



ANNUAL MEETING SEATTLE, SEPT. 9-12, 1951

President, K. L. Partlow, M.D., Olympia

Secretary, J. W. Haviland, M.D., Seattle

Executive Secretary, Mr. R. W. Neill, Seattle

Report from the State Legislature

The special legislative session, called by Governor Langlie after he vetoed the appropriations measure passed by the regular session, repassed the measure after slicing several millions of dollars from the various departmental budgets, linked the bill with a 4 per cent corporation tax and tossed it back into the lap of the governor.

He reluctantly signed the measure, but it will wind up in court under charges of being inequitable and unconstitutional. If so held, there will be another special session come summertime.

The legislators in special session also passed several other measures, including a 1 per cent real estate transaction tax, applicable only on a county basis. Spread of the sales tax to professional services and doubling of the business and occupation tax, both of which had considerable support in the regular session, were not so acceptable to the special session and the medical profession thus was saved the nuisance of collecting the sales tax on its services, nor was it subjected to the added burden of a sharp increase in the business and occupation levy.

Should the courts decide the above-mentioned questionable measure is unconstitutional, the special session anticipated by mid-summer is likely to wrap up a "package" tax plan embracing both the above proposals.

This is the time to be talking with your legislators on these matters.

Several legislators during the past sessions complained to State Medical Association representatives

against the pre-election bulletin it sent to members, classifying the legislators because of their stands on medical legislation.

They objected to being labeled as "unsatisfactory" because they had voted with drugless healers in their attempt to evade the Basic Science examinations. The answers given the complainers was—they were listed as "unsatisfactory" only insofar as their votes were at variance with the stand of the medical profession with regard to health matters. Too, it was pointed out our membership has every right to be informed of the attitudes of its legislators on these important measures.

Toward the end of the sessions, Medical Association representatives were asked by these same legislators whether the same style of report was to be made prior to the next election. It might be the legislators are beginning to feel the weight of the medical profession during elections and in legislative matters, and are looking around for means of avoiding its opposition.

Some of the most curious, as to what action the profession would pursue in the next elections, were those who were opposed by the profession, and who had narrow squeaks in the 1950 elections.

Association members should not be discouraged over the results of their past efforts in election and legislative matters. There is distinct evidence that progress is being made, and, if our activities are continued and intensified, there should be further indications our efforts are not in vain.

Annual Convention

Clem Whitaker and Leone Baxter, A.M.A.'s crack public relations team, have enthusiastically accepted President Partlow's invitation to be speakers during the Annual Convention next September.

By telephone, Whitaker informed Partlow he would have important information to bring Washington physicians. Both Mr. and Mrs. Whitaker are familiar with the Pacific Northwest and indicated it would be a distinct pleasure to make the trip out for the convention. Miss Baxter will be available to appear before the Auxiliary.

Fred Jarvis of Seattle has been designated as chairman of the scientific program. Chairman of the scien-

tific exhibits will be selected soon and a call will be sent out for volunteers in that field. All space for the technical exhibits has long been sold out and a waiting list has been compiled.

Features of the Annual Meeting will be a salmon fishing derby, golf tournament and the banquet and dance at the Town and Country Club.

Headquarters for the convention will be the Olympic Hotel and reservation blanks are being mailed to the membership. Twelve hundred physicians are expected to attend the convention and hotel reservations should be made at the earliest possible moment.

Medical Notes

NO SUBSTITUTES FOR WHOLE BLOOD. Recent report of experiments in manufacturing substitutes for blood have been to blame for misimpression on the Red Cross regional blood program, according to Harry M. Makins, medical director of the Yakima regional blood center. Many persons apparently have been under the impression that some form of blood substitute makes whole blood unnecessary, Dr. Makins said. On the contrary, he pointed out, blood donors are needed as urgently as ever, and medical science has yet to discover any substitutes to replace whole blood in treating the injured.

PHYSICIANS SKEPTICAL OF CANCER SERUM. Washington physicians don't have any of the new anti-cancer serum, krebiozen, and if they did, they would use it only experimentally, if at all. This was the flat statement by several Washington physicians recently as telephone calls swamped the Washington offices of the American Cancer Society. Hundreds of relatives of hopeless cancer patients pleaded for the drug, saying they had heard a rumor that ten physicians have supplies of krebiozen. They do not. Krebiozen, tested on only 22 patients so far, was announced last month by the University of Illinois. It is supposed to have eliminated cancer in two patients and given relief to 14 others. Eight others died. The preparation was developed by Stevan Durovic, Yugoslav physician now in Chicago.

PHYSICIANS TOLD NOT TO COUNT ON NEW DRUG. Doctors should not place too much reliance on Banthine, the new drug widely heralded as a treatment for stomach ulcers, members of the Spokane Society of Internal Medicine were told recently at their second annual meeting. Dr. Walter Lincoln Palmer, professor of medicine at the University of Chicago, said the use of Banthine should be incorporated into the general program of treatment laid out for the patient by his physician.

"It does have an inhibitory effect on the stomach because it decreases stomach activity while decreasing the acid output," he said.

AIR DROP IS SUBJECT OF CAP MEET. Methods of making an emergency air drop were demonstrated by A. J. Meyer of the Yakima civil air patrol at Richland, March 18. Meyer dropped a container of medical supplies and other equipment from his plane as part of the maneuver. The air force is studying the physician's new drop method and container and may adopt them.

Society Meetings

CHELAN COUNTY. March 7 meeting of Chelan County Medical Society was held in the Cascadian Hotel in Wenatchee. The society went on record favoring the resolution concerning the inequities in grade and pay of medical and dental officers called for active duty, which was originally propounded by the Spokane County Medical Society. The desires of this organization have been made known to the national legislators representing this area.

Frank B. Queen, Professor of Pathology, University of Oregon Medical School, presented a paper on the changing incidence of neoplasms in the population

which he correlated with a talk on the role of the pathologist in the community.

April 4 meeting of Chelan County Society heard a paper on diagnosis and management of the intestinal obstructions in infants and children by Alexander H. Bill, Jr., Seattle. A colored movie concerning the medical aspects of the atomic bomb was presented through the courtesy of Mr. Harold E. Wersen, District Safety and Health Engineer, Bureau of Reclamation, Ephrata, Wash.

J. F. Patrick, F. F. Radloff and Lecil C. Miller were named for the Chelan County Grievance Committee.

CLARK COUNTY. The regular meeting of the Clark County Medical Society was held at the Royal Oaks Country Club, Vancouver, on April 3. Following a dinner and social hour, J. Karl Poppe, Portland, gave a paper on Intrathoracic Tumors. E. L. Van Aelstyn, formerly health officer of Cowlitz County, who recently succeeded S. P. Lehman as health officer for Clark County, was introduced to the members. Announcement was made that the society would be guests of the medical personnel of Barnes Hospital at the May meeting to be held at the Officers' Club, Vancouver Barracks.

COWLITZ COUNTY. Cowlitz County Medical Society met at a regular dinner meeting, Hotel Monticello, Kelso, March 21. Merle Moore, Portland, Ore., gave a most interesting paper on Perennial Allergic Rhinitis. He stated that most of the nasal disturbances are the result of allergy and stressed the importance of an early definite diagnosis. He recommended treatment according to cause, vitamin A—100,000 units daily, avoidance of fatigue and nervousness and prohibiting allergic children from swimming in public pools. Surgery of the turbinates is to be avoided in all cases of allergic rhinitis, he said.

Harry Laudan was admitted to membership in the society.

SPOKANE COUNTY. Four Spokane physicians spoke at a meeting of the Spokane County Medical Society, March 15. David W. Gaiser and Alfred O. Adams discussed Questions and Answers on Military Procurement and Assignment. Arthur E. Lien and Milburn H. Querna discussed Medical Society Role in Civilian Defense.

YAKIMA COUNTY. Yakima County Medical Society has appointed a grievance committee to hear any complaints which may arise from patients' dissatisfaction with medical service or doctors' fees. Rex D. McClure, president of the society, appointed this committee after the plan was ratified by the membership in March. The committee has the authority to summon members of the association before it, either because of complaints against them or as witnesses in matters pertaining to other members. Mr. J. M. Cowan, executive secretary of the society, explained. If a doctor fails to respond to a summons from the committee the failure is basis for charges of nonprofessional conduct.

GENERAL PRACTITIONERS ELECT OFFICERS. R. M. O'Brien has been named president of the Spokane Academy of General Practice. Other officers include Fred C.

Harvey, vice-president, and Bert P. Jacobson, secretary-treasurer. Board members are F. E. Bertling, A. A. Sallquist, Emory F. Baker and D. W. McKinlay.

Personal

Herbert E. Coe, chief of staff at Children's Orthopedic Hospital, Seattle, participated in a panel discussion of Teamwork in the Operating Room at a four-state sectional meeting of the American College of Surgeons in Portland, Ore., March 26-27.

Glenn A. Warner, Ellensburg, has recently opened offices in the Court Apartments on the east side of the town. Warner received his medical degree from George Washington University in Washington, D. C., interned at Southern Pacific Hospital, San Francisco, and took special training at San Mateo County Hospital, San Mateo, Calif. He has been practicing with Ralph Pinekard in Ellensburg.

Elizabeth M. Welty has been approved as the first woman member of the Spokane Society of Internal Medicine, according to Merritt H. Stiles, president. She was installed at the annual banquet March 31 at the Davenport Hotel.

H. Eugene Patterson, Yakima pediatrician, has taken a year's leave of absence to undertake graduate training at the Harvard Medical School, Massachusetts General Hospital in Boston.

A number of Washington physicians were among those attending the five-day postgraduate course in general surgery given recently at the University of Oregon Medical School. These included E. G. Bond and E. G. Peacock of Spokane, Charles R. Mowery, Jr., Yakima, and Fred F. Parke, Longview.

Almost two hundred physicians from the State of Washington attended the three-day cancer refresher course at the University of Washington School of Medicine March 8-10, sponsored by the Washington Division of the American Cancer Society. Costs of the course, paid from funds donated to the annual April Cancer Campaign in Washington, are borne by the society and classes were tuition-free to the physicians. The course was a part of the society's continuous attempt to focus attention on cancer and the importance of early recognition and prompt treatment for its control, Clyde R. Jensen, chairman of the American Cancer Society's executive committee, said.

Newly returned to the Pacific Northwest after five years' association with the Mayo Clinic at Rochester, Minn., Franklin R. Smith has become associated with Doctors' Clinic in Bremerton. He will also maintain a practice in Seattle.

Thomas Angland, Yakima, now taking a year of special work at the University of Iowa, is more than satisfied with his studies. He has written enthusiastically to friends in Yakima:

"I am very grateful for the opportunity and know that I can bring back to our good town a better brand of medicine. This is an exciting business with almost unbelievable opportunities for new methods and many

times a discovery that some 'homely' old principle is far better than shiny chrome and jet propulsion can deliver."

Lloyd M. Farner, Seattle, Medical Administrative Consultant, Division of Vocational Rehabilitation, Washington State Board for Vocational Education, has received a Fellowship for European study. This is a United Nations grant given through the World Health Organization. Dr. Farner will spend a month in England and two weeks each in Sweden, Austria and Germany. He will study industrial medical practice in these countries, giving special attention to rehabilitation of the industrially injured. Dr. Farner's interest in this foreign study was stimulated by visits of foreign rehabilitation specialists while he was working in industrial medicine with the Public Health Service. From some of the visitors he gathered the impression that care of industrial injuries in European industrial health clinics is somewhat better coordinated than in this country. The patient is carried through some of these clinics from his emergency medical care to his complete rehabilitation and restoration to gainful occupation. Report of this study will be interesting.

Hospital News

Most exciting news to be presented to the guilds and auxiliaries of the Children's Orthopedic Hospital Association of Seattle March 2 at the annual meeting was that \$3,100,000 is now in the building fund and that actual construction of the new hospital will soon be under way. It was also encouraging news that the hospital was in the black to the tune of \$25,000 this year, whereas many years it has operated in the red. Monthly expense at the hospital averaged \$65,000 in 1950. The hospital has listed 136 physicians and there are voluntary nurses who gave 15,847 hours last year to work in the hospital and annex, equalling eight full-time nurses.

It was announced that the American Hospital Association meeting in 1950 in Atlantic City presented the Orthopedic Hospital with a bronze plaque for representing excellency in public relations for all hospitals of the country with 200 beds or less.

The quarter-million-dollar remodeling job in the Kadlec Hospital, Richland, will start in about a week and is expected to be finished late in the summer. Ralph Sachs, Richland's public health officer, will act as contact engineer between General Electric Company's medical divisions and the contractor. Sachs said that an "L" will be added to the obstetrics ward, additional space will be provided for the laboratory and x-ray wing, the hospital kitchen will be remodeled and the floors of the corridors will be recovered.

Albert Allen, medical director at Central Washington Tuberculosis Hospital in Selah, reports that the bed situation at the hospital is critical. The hospital opened January, 1950, with 110-bed capacity, but that capacity has been increased to 153 beds by converting single rooms to double ones, Allen said. Of the 151 patients in the hospital today, 120 are

from Yakima County and the rest from five other counties.

Mr. Donol F. Hedlund, Seattle businessman, has been appointed to the board of directors of Swedish Hospital, Mr. John A. Soderberg, board president, announced April 4.

The new 40-bed general hospital at Northgate, Seattle, was opened April 1. Operated by Northgate Surgery, Inc., the hospital includes 16 beds for obstetrical patients. The maternity department will be run on a "rooming in" plan, which provides for the newborn infant to live in the same room with the mother. Physicians and dentists' offices occupy other floors of the building.

Immediate expansion of Harborview County Hospital, Seattle, was assured March 22. The Board of King County Commissioners decided to offer for sale immediately \$2,750,000 in bonds approved by voters in 1948 for construction of a new wing at Harborview. The bonds were not offered for sale earlier because Initiative 172, which permitted welfare patients to go to any hospital of their own choosing, caused a decrease in the patient load at the county hospital. Now, with Initiative 178 in effect, the hospital again is overcrowded, according to hospital trustees, who recently asked the commissioners to proceed with the bond sale and begin construction of the new wing as soon as possible.

Hospital Staff Meetings

Regular monthly staff meeting of the General Hospital of Everett was held March 27 at the Jordan Home following a buffet dinner. Following a short

business meeting, Paul Bishop and Harold Gunderson presented a case of polycythemia rubra vera with discussion of therapy by Richard Kiltz. Charles Mincks and Ed Chase discussed a case of intussusception with multiple abdominal herniae. Vince Meyer presented a new concept on the etiology of retrolental fibroplasia.

New officers of the staff were presented and took over their duties of office. These included: President, Richard Kiltz; vice-president, Kenneth Barnes, and secretary-treasurer, Floyd D. Levin.

More than one hundred fifty staff members attended the annual meeting of the Deaconess Hospital medical staff, held at the Spokane Hotel on March 13. The following were granted Emeritus Staff status: D. H. Lewis, H. E. Rhodehamel, J. G. Harbison, Emil M. Welty and E. R. Northrop. J. N. Sledge was granted Active Staff membership.

The following officers were elected for the coming year: David W. Gaiser, president; W. E. Newman, vice-president, and E. B. Coulter, secretary - treasurer. Voted on the Executive Committee for two-year terms were A. Bruce Baker, Harry P. Lee and Robert F. Welty.

Mrs. Katherine Lehman, R.R.L., Medical Record Librarian, and Miss Orpha Henneck, Assistant Medical Record Librarian, were presented with gifts by the medical staff.

F. Scott Pennepacker presented the annual unscientific paper and awarded Elizabeth B. White the Seventh Annual Staff "Oscar" for an outstanding accomplishment during the past year, i.e., performing four deliveries in fifty-eight minutes and seventeen seconds.

Public Relations

A comprehensive and detailed public relations report adopted by Washington State Medical Association Public Relations Committee and approved last week by the State Executive Committee is published below.

The report provides detailed instructions on the state and county levels for the guidance of all public relations activities and personnel. It is the first report of its kind adopted by Washington State Medical Association and follows a year of careful study under the direction of Frank H. Douglas, committee chairman.

Mr. Howard Barnes, Public Relations Director of Washington State Medical Association, will direct the program throughout the various counties of the state. The Public Relations Committee which presented the report is composed of the following:

Frank H. Douglas, Seattle, chairman; H. F. Brundage, Yakima; George H. Drumheller, Everett; David W. Gaiser, Spokane; Clark C. Goss, Seattle; Joseph L. Greenwell, Pasco; Homer W. Humiston, Tacoma; Quentin Kintner, Port Angeles; Harold B. Larsen, Bremerton; David H. Lewis, Spokane, and Asa Seeds, Vancouver.

"Public Relations Is Practical Public Service"

Good public relations depends upon good works—not so much on how widely we are known, but on how favorably we are known.

You—the individual physician—and your County

Society can do more to improve your public relations than any other person or group.

We sincerely ask for your advice, suggestions and criticisms.

WASHINGTON STATE MEDICAL ASSOCIATION
PUBLIC RELATIONS COMMITTEE

Objectives

Your committee sets forth these objectives so that you will have them before you constantly. You are urged to check and recheck them as we go along to determine if they are being pushed, or if some are being neglected, in your area of medical care. The following objectives will form the basis of future public service activities:

1. The promotion of a better understanding between the public and the medical profession, and the problems of both, by:

- A. Constantly surveying public opinion and frankly informing the profession of constructive criticism; taking representative polls to learn specific and peculiar complaints of both patients and non-patients against doctors, hospitals, nurses, and medical care generally.

- B. Informing the public in detail of the problems peculiar to medical care and service, tactfully pointing out how they can be better patients and thereby derive more benefits from treatment.
- C. Acquainting the public, through every available medium, of the increasing efforts of the medical profession to extend high-quality care to every economic and geographic area.
- D. Working actively with all lay organizations (P.-T. A., health councils, civic clubs, etc.) to promote better health and living standards throughout Washington state.

Policies

Our policies will be broad and forthright. When fitted into the objectives and the program, they will assure the preservation of the high ideals and ethics of the profession.

1. To support and maintain the free practice of medicine, as it now exists—a basic component of the American system of competitive enterprise; to fight political medicine, NOT as an isolated group, but as citizens fighting the broader trend toward complete socialism.

2. In working with lay organizations, follow up the meetings and programs with a checkup system to see that plans for progress do not die with the resolutions in which they were born.

3. See that our public relations program carries its humanitarian interest to all the people; and that it places greater emphasis upon performance than upon publicity.

Program

We present below the specific steps to be taken in the development of a real program of public relations:

1. The employment of a field man to spend his full time in carrying out this program.

2. An all-out educational program to inform the membership of the importance of good public relations, so they will tackle the problems and take advantage of the opportunities that arise every day in our work and contacts:

- A. Ask each county society to name a Public Relations Committee.
- B. Constantly inform the public of the progress of medical service and science in Washington; of plans of the profession for the future; of the causes of medical costs, with emphasis on improved results and reduced time of illness; and urge the public to join in efforts to extend medical care. Health is everybody's responsibility.
- C. Encourage every newspaper in the state to publish an annual medical supplement.
- 3. Foster a renaissance of professional ethics:
 - A. Guard high standards of practice:
 - (1) Re-study legislation to protect medical ethics.
 - (2) Promote studies of hospital relationships to the practice of medicine by Professional and Hospital Relations Committees.

- B. Maintain a close observation of excessive fees.
- C. Request the larger local societies to establish grievance committees, and all societies to actively use the facilities of the newly created Grievance Committee of the State Association.
- D. Actively clean our own house on the local level.

E. Broaden and improve relationships regarding consultations.

4. Extend the availability of medical care and increase the value of the investment in health:

- A. Intensify the promotion of *voluntary* prepayment health insurance plans of all types.
- B. Promote cooperation with insurance companies to simplify and shorten report forms.
- C. Recognize and foster voluntary prepaid insurance and the Medical Bureaus for what they are: "The best solution yet found, and the one which provides the greatest benefit to the most people."

5. Conduct active campaigns to recruit nurses and encourage the establishment of practical nurse training schools; provide an adequate supply of laboratory technicians and other professional aides.

6. Render public service through participation by physicians and societies in public affairs; engage in carefully selected and worthy civic and governmental programs for the health and welfare of the people; register the profession 100 per cent for voting, and use the franchise right:

- A. Oppose regimentation and fight for restoration of the government to the people.
- B. Urge all groups with similar goals to join the medical profession in its fight against socialism.
- C. Know your state legislators personally, and seek their cooperation and understanding; begin a concerted campaign to see that there are doctors elected to the State Legislature.
- D. Encourage public speaking courses for doctors and use of members of medical speakers' clubs before lay groups.

7. Cooperate with health protection efforts of the state and county departments, Women's Auxiliary to the Washington State Medical Association and other voluntary organizations such as the Cancer Society, Heart Association, Society for Crippled Children, Tuberculosis Association, the American Red Cross; make personal contributive efforts to all civilian defense preparedness.

8. Cooperatively integrate the work of the W.S.M.A. Grievance Committee, the Professional Relations Committee and the Public Relations Committee.

9. Establish a public information service in the larger cities and publicize its existence:

- A. Improve emergency call procedures and urge the profession to accept such calls as a public service.

10. Adopt a "Press and Radio Code of Cooperation" to promote better understanding between the professions and to provide a working agreement for the spread of medical science news. Parties to the agreement should be the trustees of the W.S.M.A. and the directors of the Washington State Press Association, the State Association of Broadcasters and the Washington State Hospital Association.

11. Encourage members of the profession and their friends to contribute to the American Medical Education Foundation.

REMEMBER: Doctors are more accustomed to giving advice than receiving it, and their public relations has suffered accordingly. There is a growing realization that the individual physician must participate in and support the organization of which he is a part.

Spotlight on Service

Below are a few news notes on some typical activities, representing not all, but a cross-section of the public service constantly being rendered by physicians. The Washington State Health Council, 905 Second Avenue Building, Seattle, prepared these notes for NORTHWEST MEDICINE and welcomes any contributions on activities in your area.

BELLINGHAM'S POLIO ADVISORY TEAM



Shown here inspecting a Hubbard Tank recently installed in St. Joseph's Hospital are four of the five Whatcom County physicians who make up the medical advisory committee to the Whatcom County Chapter of the National Foundation for Infantile Paralysis. They are L. A. Greenwood, chairman; Donald C. Keyes, W. C. Moren and James Stancil. Frank Tabrah, also a member, was not present when this picture was taken.

Typical Polio Advisory Team

In its broad program of research, education and patient care, the National Foundation for Infantile Paralysis is faced each day with decisions that can be made only by medical men. Should this child be admitted to a hospital as a polio patient? Is this child ready to go home? Does this one require orthopedic surgery? Is this bill correct?

For each of its county chapters in Washington, the National Foundation has established a medical advisory committee. The committee consists of local physicians particularly interested or with special skills in the field of poliomyelitis. Generally, the committee is named by the local medical society.

It is estimated that four out of five decisions made by each chapter are guided, directly or indirectly, by the advice of this key committee. No chapter is permitted to operate without such a committee.

In Washington, well over a hundred physicians are members of local medical advisory committees. Meeting as frequently as required, they volunteer their time, skills and knowledge so that the Foundation's financial help to patients can be expended in the most beneficial way, and with the least disturbance to the doctor-patient relationship.

Typical of the activities of these committees is the work done by the Whatcom County medical advisory committee. Currently, the committee members:

- (1) Serve as admissions consultants on all suspect cases.
- (2) Upon request of the attending physician, serve as specialist consultants.
- (3) In cooperation with the chapter, sponsor professional education for medical and allied groups.
- (4) Make recommendations and serve as liaison in fees and billings subject to question.
- (5) Make recommendations upon proposed surgery when chapter financial aid is involved.
- (6) Study possible epidemic needs for additional equipment and personnel, in order that the county may meet emergencies that arise.

Mr. Felix Montes, Washington state representative, says: "Since the care of poliomyelitis patients is the major concern of each chapter, the medical advisory committee is one of the keystones of our work. Without the time and effort given by these physicians, our program would soon be at a standstill."

Civil Defense Activities

In these uncertain days, doctors are being called on for public service far above their peacetime quota, always heavy enough. While younger men, particularly those who received government aid in their training, are called to military duty, those remaining at home have a heavy responsibility in civil defense.

The State Medical Association months ago helped take leadership in getting the wheels rolling for the staggering job of making arrangements for casualties of atomic attack—a situation which might give a dead-and-injured list in excess of 100,000 in a city with 90 per cent of doctors and hospitals knocked out. More than four hundred Washington doctors turned out last fall for a jam-packed three-day course in medical aspects of atomic warfare.

Washington's civil defense plans are headed by the newly created Department of Civil Defense. Medical services are represented by J. A. Kahl, acting director of the State Department of Health, in this general staff setup. However, it's at home in the counties where the real work gets done, and this work has been speeded notably by the prompt action of each county society in naming a civil defense committee. There is also a state civil defense committee which works closely with the State Health Department and other medical-service groups, to lay out over-all plans so that each county can contribute its share of doctors, nurses, hospital supplies, technicians, etc.

SALCIPAB TABLETS

Contain: **TWO ACTIVE** antirheumatic agents—
Sodium Para-Aminobenzoate 5.0 gr. (0.3 Gm.)
Sodium Salicylate USP 5.0 gr. (0.3 Gm.)
Supplied on prescription only.

Sodium Salicylate in combination with Sodium Para-Aminobenzoate achieves a higher salicylate blood level than does Sodium Salicylate alone.

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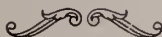


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The county civil defense unit is the real hub of this operation, and for that reason the civil defense chairman from each county society is a member of the state committee. Kenneth Whyte and Frank J. Leibly of Seattle are co-chairmen, while A. B. Murphy, Everett, and Scott S. Jones, Tacoma, are vice-chairmen. Dr. Kahl is secretary. The remaining members are chairmen of their local civil defense units: Stanley R. Benner, Yakima; Maurice E. Bryant, Colfax; Harry Plut, Port Townsend; Milton P. Graham, Aberdeen; Robert M. Hill, Ellensburg; George E. Hoxsey, We-

natchee; Reed Ingham, Olympia; W. L. Jackson, Burlington; Robert O. Luehrs, Vancouver; A. A. Yengling, Walla Walla; Murray L. Johnson, Tacoma; Glen L. Mathis, Longview; Wesley C. Minzel, Colville; J. L. McFadden, Port Angeles; John McGregor, Bellingham; L. E. Foster, Bremerton; S. A. Porter, Okanogan; J. R. Rehal, Stevenson; R. R. Sachs, Richland; James C. Brock, Yakima; J. E. Toothaker, Centralia; E. L. Turner and Bruce Zimmerman, Seattle; J. Walton Darrough, Everett; R. Bussabarger, Raymond, and M. H. Querna, Spokane.



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ANNUAL CONVENTION ALASKA TERRITORIAL MEDICAL ASSOCIATION

KETCHIKAN, ALASKA
MAY 31, JUNE 1-2, 1951



DWIGHT CRAMER
President

GUEST SPEAKERS

MEDICAL CARE PROBLEMS IN POLIOMYELITIS
RESEARCH PROGRESS IN POLIOMYELITIS
Kenneth Landauer, M.D., New York City

WHAT ABOUT HORMONES AND CANCER?
TOTAL vs. SUB-TOTAL HYSTERECTOMY
Ludwig A. Emge, M.D., San Francisco, California

DIZZINESS
TENSION STATES
Laurence Selling, M.D., Portland, Oregon

DIFFERENTIAL DIAGNOSIS IN JAUNDICE
THE ROLE OF POTASSIUM IN DISEASE
Hugh Jones, M.D., Seattle, Washington

MANAGEMENT OF THYROID DISEASE
ACTH AND CORTISONE, THEIR USES AND ABUSES
J. H. Crampton, M.D., Seattle, Washington

EYE DISEASES FROM THE STANDPOINT OF THE GENERAL PRACTITIONER
Milo Fritz, M.D., Anchorage, Alaska

TUBERCULOSIS CLINIC
Fred Coddington, M.D., Sitka, Alaska
Francis J. Phillips, M.D., Seward, Alaska

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DWIGHT CRAMER, M.D., BOX 547, KETCHIKAN, ALASKA

*The convention is being held just prior to the famous Ketchikan Fishing Derby.
First Prize for the day is a Pontiac sedan.*

IDAHO STATE MEDICAL ASSOCIATION

Fifty-Ninth
Annual Meeting

SUN
VALLEY
IDAHO

JUNE
18, 19, 20
1951



RUSSELL T. SCOTT
President, Idaho State Medical Association

An Invitation . . .

On behalf of the Officers and Councilors and the Program Committee of the Idaho State Medical Association, I would like to extend to every member of the medical profession in the Northwest a very warm and cordial invitation to join with us at Sun Valley to participate in the 59th annual meeting of the Idaho association.

Six nationally prominent physicians and surgeons have accepted invitations to present scientific papers at our meeting of current interest to general practitioners and specialists alike.

Our meeting will be held at Sun Valley, one of America's truly delightful resorts, where abundance of recreation, relaxation, resting and enjoyment awaits you.

Our scientific sessions have been planned to provide long afternoon hours of recreation, golf, horseback riding, skating or just plain loafing. Each evening a delightful and entertaining function has been planned, including the Annual Barbecue at Trail Creek, our Annual Stag and Stagette Party, and our Annual semi-Formal Banquet.

House of Delegates meetings are being streamlined to provide additional free time for the scientific sessions or fun.

We know that you will have a delightful time at our 59th annual meeting.

We look forward to seeing you at Sun Valley.

Cordially,

RUSSELL T. SCOTT, M.D.
President

G U E S T S P E A K E R S



DONALD G. TOLLEFSON, M.D., *Los Angeles, Diplomate, American Board of Obstetrics and Gynecology; Chairman, Executive Committee, The White-Moore Clinic.*

Subjects:

Practical Problems in Obstetrics.

1. The Third Stage of Labor.
2. Breech Delivery.
3. Prolonged Labor.
4. Treatment of Toxemia.
5. Anaesthesia and Analgesia.
6. Indications for Therapeutic Abortion.

Practical Problems in Gynecology.

1. Leucorrhea.
2. Management of the Menopause.
3. The Sterility Patient.
4. Retroversion of the Uterus.
5. The Cystic Ovary.
6. Tumors of the Ovary.

HARRY H. GORDON, M.D., *Denver, Professor of Pediatrics, University of Colorado Medical School.*

Subjects:

- Modern Trends in Infant Feeding.
- Some Problems in the Care of Premature Infants.
- Iso-Immunization.
- Treatment of Acute Rheumatic Carditis, including Hormone Therapy.



CURTICE ROSSER, M. D., *Dallas, Professor and Head of the Department of Proctology, Southwestern Medical College of the University of Texas.*

Subjects:

- Diverticulitis.
- Bazzare Tumors of the Rectum.
- Management of Common Ano Rectal Lesions.
- Pruritis Ani.



GUEST SPEAKERS

D. L. C. BINGHAM, M.D., *Kingston, Ont., Professor of Surgery, Queens University, Kingston, Ont.*

Subjects:

Chronic Venous Insufficiency (A Clinical Problem for Diagnosis and Treatment).

Obliterative Peripheral Arterial Disease.

Carcinoma of the Rectum and Colon.

Surgery of the Sympathetic Nervous System.



JOHN Z. BOWERS, M.D., *Salt Lake City, Dean of the University of Utah School of Medicine.*

Subject:

Some Aspects of the Atomic Bomb.

GEORGE W. THORN, M.D., *Boston, Mass., Professor of Practice of Physic, Harvard University Medical School.*

Subjects:

Clinical Evaluation of ACTH and Cortisone.

Treatment of Uremia.

Treatment of Gout.

Treatment of Thyrotoxicosis.



GENERAL INFORMATION

The Registration Desk will be in the Lobby of the Challenger Inn and will open at 11 a. m., Sunday, June 17, 1951.

First meeting of the House of Delegates will be on Sunday, June 17, 1951, beginning at 1 p. m., in the Challenger Inn Skiers' Cafe. Delegates are urgently requested to attend this meeting.

Scientific sessions will be held in the Opera House, Monday, June 18; Tuesday, June 19, and Wednesday, June 20, beginning at 9:30 a. m., and will end at 1 p. m. except on Wednesday, when a round table discussion will be held starting at 2:30 p. m. with guest speakers serving as panel members.

Accommodations will be at the Challenger Inn. Adjoining rooms with shared bath can be arranged if requested.

Evening social functions scheduled include the Annual Barbecue on Monday; the Annual Stag and Stagette on Tuesday, followed by the Ice Follies, and the Annual Banquet on Wednesday night which will be semi-formal.

RESERVATION REQUEST

59th Annual Meeting

DR. JOHN R. MORITZ, Sun Valley, Idaho

Please make the following reservation for me:

Room reservations: Single.....Double.....

Will arrive 1951.....

Car

Train

Name

Address.....

(Because another Convention will be at Sun Valley immediately before our meeting, the management has requested you plan your arrival for Sunday morning, June 17, 1951)

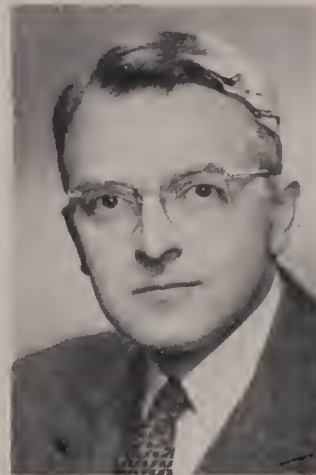
Postgraduate Assembly in Endocrinology Including Diabetes



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Johns Hopkins Hospital
Baltimore, Maryland



E. PERRY McCULLAGH, M.D.
Cleveland Clinic
Cleveland, Ohio



WILLARD M. ALLEN, M.D.
Washington University
St. Louis, Missouri

Olympic Hotel, Seattle, Wash., July 2-7, 1951

Program

Monday, July 2

General, Thyroid, Adrenals

- 9:00 a. m.—General Principles of Endocrinology, Peter Forsham
- 9:20 a. m.—Pituitary Physiology and Chemistry, R. H. Williams
- 9:40 a. m.—Thyroid Physiology, Alexander Albert
- 10:00 a. m.—Diagnostic Tests of Thyroid Disease, Elmer Bartels
- 10:20 a. m.—Intermission—Refreshments
- 10:30 a. m.—Treatment of Thyrotoxicosis, Bartels
- 11:00 a. m.—Treatment of Myxedema, P. McCullagh
- 11:10 a. m.—Diagnosis and Treatment of Hypometabolism, McCullagh
- 11:20 a. m.—Diagnosis and Treatment of Non-toxic Goiter and Cancer; Tumors of Neck, Bartels
- 11:50 a. m.—Diagnosis and Treatment of Thyroiditis, Brien King
- 12:00 noon—Case Presentations
- 12:45 p. m.—Luncheon
- 2:00 p. m.—Questions and Answers, Williams, Moderator
- 2:30 p. m.—Adrenal Physiology, Forsham
- 3:00 p. m.—Adaptation Syndrome, Edward Reifstein
- 3:45 p. m.—Diagnostic Tests of Adrenal Function, Albert
- 4:15 p. m.—Diagnosis and Treatment of Cushing's Disease, Bartels
- 4:35 p. m.—Diagnosis and Treatment of Acute and Chronic Adrenal Insufficiency, Forsham

Tuesday, July 3

Adrenals, Testes, Ovaries

- 9:00 a. m.—ACTH and Cortisone, Albert
- 9:30 a. m.—ACTH and Cortisone, Forsham

- 10:00 a. m.—Diagnosis and Treatment of Adrenogenital Syndrome, Hirsutism and Intersexuality, Lawson Wilkins
- 10:20 a. m.—Intermission—Refreshments
- 10:30 a. m.—Adrenals (Cortex and Medulla) and Hypertension, Bartels
- 11:25 a. m.—Case Presentations
- 12:00 noon—Questions and Answers, Wilkins, Moderator
- 12:30 p. m.—Luncheon
- 2:00 p. m.—Physiology of Testis, Heller
- 2:20 p. m.—Functional Castrates—Hypogonadotropic Eunuchoidism—Hypogonadism Secondary to Pituitary Failure, McCullagh
- 2:50 p. m.—Male Climacteric and Uses of Androgens in the Male, Carl Heller
- 3:10 p. m.—Intermission—Refreshments
- 3:25 p. m.—Gynecomastia, Henry H. Turner
- 3:35 p. m.—Case Presentations
- 4:15 p. m.—Questions and Answers, Hans Lisser, Moderator
- 4:45 p. m.—Ovarian Physiology, Albert

Wednesday, July 4

Ovaries, Pregnancy

- 9:00 a. m.—Diagnostic Tests of Gonadal Function, Albert
- 9:30 a. m.—Metropathia Hemorrhagica, Allen
- 9:50 a. m.—Dysmenorrhea and Endometriosis, Allen
- 10:10 a. m.—Female Hypogonadism, Ovarian Agenesis and Turner's Syndrome, Turner
- 10:20 a. m.—Premenstrual Tension—Mastodynia, Allen
- 10:35 a. m.—Intermission—Refreshments
- 10:50 a. m.—Amenorrhea, Reifstein
- 11:05 a. m.—Menopause, Arthur Rogers
- 11:25 a. m.—Chronic Cystic Mastitis, Micro and Macromastia, Lactation, Allen

- 11:45 a. m.—Variations in the Patterns of Adolescence; Precocious and Delayed Puberty, Wilkins
 12:30 p. m.—Chorionepithelioma and Hydatidiform Mole, R. de Alvarez
 12:45 p. m.—Luncheon
 2:00 p. m.—Male and Female Sterility, Heller
 2:30 p. m.—Habitual Abortion, Toxemias of Pregnancy, Pregnancy in Diabetics, Allen
 3:00 p. m.—Hormonal Treatment of Cancer of Breast and Prostate, Donald McDonald
 3:20 p. m.—Ovarian Tumors, Allen
 3:40 p. m.—Intermission—Refreshments
 3:55 p. m.—Case Presentations
 4:30 p. m.—Questions and Answers, Turner, Moderator

Thursday, July 5

Pituitary, Parathyroid, Bone, Nutrition, Pseudo-endocrinopathies, Neuroendocrines

- 9:00 a. m.—Neurohypophyseal Interrelationships, Harold D. Patton
 9:20 a. m.—Psychodynamic Aspects of Endocrinology, E. Kost Shelton
 9:40 a. m.—Tumors of Pituitary, McCullagh
 9:55 a. m.—Treatment of Acromegaly, Lissner
 10:25 a. m.—Simmonds' Disease and Anorexia Nervosa, Lissner
 10:25 a. m.—Diabetes Insipidus, Ben Vidgoff
 10:35 a. m.—Hypo and Hyper Parathyroidism, Reifensstein
 10:55 a. m.—Intermission—Refreshments
 11:10 a. m.—Osteomalacia, Osteoporosis and Other Metabolic Bone Diseases, Reifensstein
 12:05 p. m.—Hormones and Nutrition, Albert
 12:30 p. m.—Luncheon
 2:00 p. m.—Endocrine and Other Factors Concerned with Somatic Growth, Wilkins
 2:40 p. m.—Androgen Therapy of Prematurity, Shelton

- 2:50 p. m.—Hypothyroidism in Children, Wilkins
 3:10 p. m.—Intermission—Refreshments
 3:25 p. m.—Obesity and Thinness, Williams
 3:45 p. m.—Hormone Preparations; Abuse of Hormone Therapy, Shelton
 4:10 p. m.—Questions and Answers, Shelton

Friday, July 6

Lester Palmer presiding—Opening Remarks

- 8:30 a. m.—Modern Concepts and Recent Experimental Aspects of Diabetes, Henry Ricketts
 9:15 a. m.—Physiological Action of Insulin, Forsham
 9:45 a. m.—Diagnostic Problems and the Proper Use of Laboratory Tests, Francis Lukens
 10:15 a. m.—Intermission and Viewing of Exhibits
 10:30 a. m.—Clinic: Presentation of Cases, Discussants: Blair Holcomb, Howard Root, McCullagh, Ricketts and Forsham
 11:30 a. m.—Selection of the Proper Diabetic Diet, Ricketts
 12:00 noon—Demonstration of Teaching of a Class of Diabetics by the Physician and Dietitian, Holcomb

Luncheon

Howard Root presiding

- 2:00 p. m.—Various Insulins and How to Use Them, James Sherrill
 2:30 p. m.—Insulin Problems: Sensitivity, Resistance, Allergy, Local Lipodystrophy, Lukens
 3:00 p. m.—What Constitutes Diabetic Control—Long Term Results, Root
 3:45 p. m.—Intermission and Viewing of Exhibits
 4:00 p. m.—Diabetes in the Surgical Patient, McCullagh
 4:45 p. m.—Panel: Questions and Answers

Evening

Public Meeting—Panel from the Faculty—Auspices of Lay Society of Washington Diabetes Association.

FOURTH ANNUAL POSTGRADUATE ASSEMBLY IN ENDOCRINOLOGY INCLUDING DIABETES

Sponsored by
THE ASSOCIATION FOR THE STUDY OF INTERNAL SECRETIONS
and
THE AMERICAN DIABETES ASSOCIATION

SEATTLE, WASHINGTON • OLYMPIC HOTEL • JULY 2-7, 1951

The faculty will consist of prominent researchers and clinicians in the field of endocrinology and metabolic disorders.

The course will be a practical one of interest and value to the specialist and those in general practice. The program will consist of lectures, clinics, and demonstrations. Ample time will be given to questions and answers at the end of each session, and registrants are encouraged to contact members of the faculty for individual discussions.

The Olympic, one of Seattle's most delightful hotels, offers special convention rates to members of this assembly. This is an unusual opportunity for you and your family to enjoy a pleasant vacation in the beautiful Pacific Northwest and for you to participate in a highly instructive program of the latest advances in endocrinology and metabolism.

A fee of \$75 will be charged for the entire course and the attendance will be limited to 100. REGISTRATION WILL BE IN THE ORDER OF CHECKS RECEIVED AND WILL CLOSE ON JUNE 4, 1951. Should there be an insufficient number of applicants to fill the course, the registration fee will be refunded immediately in its full amount.

Please forward application on your letterhead, together with check payable to The Association for the Study of Internal Secretions, to Henry H. Turner, M.D., Secretary-Treasurer, 1200 North Walker Street, Oklahoma City 3, Oklahoma, before June 4, 1951. Further information and program will be furnished upon request.

Hotel reservations should be made directly with the Olympic Hotel, Seattle, Washington, and the hotel advised that you are attending this Postgraduate Assembly.

Saturday, July 7

James Sherrill presiding

- 8:30 a. m.—Presentation of Cases. Discussants: Sherrill, Palmer, Homer Rush and Lukens
- 9:30 a. m.—Diabetic Pregnancy, Palmer
- 10:00 a. m.—The Diabetic Child, Sherrill
- 10:30 a. m.—Intermission and Viewing of Exhibits
- 10:45 a. m.—Diabetic Retinopathy and Nephropathy, and other Renal Complications, K. Swan
- 11:15 a. m.—Diabetic Neuropathy, Ricketts
- 11:45 a. m.—Diabetic Statistics and How to Use Them, Root

Luncheon

Francis Lukens presiding

- 2:00 p. m.—Disorders of the Heart and Large Blood Vessels in Diabetes, Rush
- 2:30 p. m.—Peripheral Vascular Disease and Gangrene, Swan
- 3:00 p. m.—Treatment of Diabetic Coma, Root
- 3:45 p. m.—Intermission and Viewing of Exhibits
- 4:00 p. m.—The Future of Diabetes and Its Prevention, Sherrill
- 4:30 p. m.—Panel: Questions and Answers

Announcements of Meetings

Cancer Symposium—University of Oregon, Eugene, Oregon

June 2, 1951

This symposium is being conducted by the Central Willamette Medical Society and will start at 9 a.m. The lecture will be held in the University theater on the University of Oregon campus. The luncheon and dinner round tables will be held at the Eugene Hotel. Speakers and their subjects include:

Lyman M. Stowe, assistant professor of obstetrics and gynecology, Stanford University—Carcinoma of Cervix and Endometrium; Fred L. Reichert, professor of surgery at Stanford University—Malignancies in

the Field of Neurosurgery; Roland D. Pinkham, instructor in surgery, University of Washington School of Medicine—Neoplastic Lesions of the Lungs and Esophagus; Otto H. Pfeuger, instructor of surgery, University of California—Cancer of the Tongue and Mouth; Ole Andy Nelson, Seattle—Cancer of the Kidney; Daney Phillips Slaughter, assistant professor of surgery, University of Illinois—Recent Advances in Cancer Therapy; John T. Reynolds, Assistant Professor of Surgery, University of Illinois—Cancer of the Colon.

Admission is free. Further inquiries should be addressed to Arthur P. Martini, M.D., Pent House, Eugene Medical Center, Eugene, Ore.

Postgraduate Courses

University of Oregon Medical School

Electrocardiography—June 11-15, 1951

This course is designed to meet the needs of physicians in general practice as well as those particularly interested in electrocardiography. The faculty will include Francis L. Chamberlain, M.D., assistant professor of medicine, University of California Medical School (guest instructor), and the following physicians from the University of Oregon Medical School: Homer P. Rush, clinical professor of medicine, head of Division of Cardiology; Marvin Schwartz, clinical instructor in medicine; Isidor C. Brill, associate clinical professor of medicine; Herbert E. Griswold, Jr., assistant professor of medicine; Hance F. Haney, associate professor of medicine, and Frank Underwood, assistant clinical professor of medicine.

Registrations and inquiries should be addressed to Director of Postgraduate Instruction, University of Oregon Medical School, 3181 S. W. Sam Jackson Park Road, Portland 1, Ore.

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, two weeks, starting May 14, June 4, June 18.
Surgical Technic, Surgical Anatomy & Clinical Surgery, four weeks, starting June 4, July 9, August 6.
Surgical Anatomy & Clinical Surgery, two weeks, starting May 14, June 18, July 23.
Surgery of Colon & Rectum, one week, starting June 4, September 17.
Esophageal Surgery, one week, starting June 4.
Thoracic Surgery, one week, starting June 11.
Gallbladder Surgery, ten hours, starting June 18.
Breast & Thyroid Surgery, one week, starting June 25.
Fractures & Traumatic Surgery, two weeks, starting June 18.

GYNECOLOGY—Intensive Course, two weeks, starting June 18, September 24.
Vaginal Approach to Pelvic Surgery, one week, starting June 11, September 17.

OBSTETRICS—Intensive Course, two weeks, starting June 4, September 10.

MEDICINE—Intensive General Course, two weeks, starting October 1.
Gastroenterology, two weeks, starting October 15.
Gastroscopy, two weeks, starting July 16.
Electrocardiography & Heart Disease, two weeks, starting July 16.
Liver & Biliary Diseases, one week, starting June 4.

PEDIATRICS—Cerebral Palsy, two weeks, starting July 9.
One Year Full Time Clinical Course starting July 2.

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Research Projects

Report on Research Work in Progress at the University of Oregon Medical School

Subject: Anatomy and physiology of the auditory system under the direction of Dr. Archie Tunturi.

Objectives: Better understanding of hearing, leading to improvement of communication equipment, underwater sound devices for warfare, and diagnosis and treatment of hearing defects.

Progress: Method devised for physiological study of minute cortical anatomy. Analysis of auditory cortex into four subdivisions. Analysis of individual areas in relation to physical qualities of sound. Anatomic study of connection to areas. Location of sight of stimulation of sounds in cochlea.

Subject: The lobules of the cerebellum and agenetic cerebella under the direction of Dr. Olof Larsell.

Objectives: A complete anatomical analysis of the cerebellum and its connections with the other parts of the nervous system is necessary for understanding the functions of this organ in health and disease.

Progress: A detailed morphological analysis of the mammalian and the human cerebellum is nearly completed. The results show a pattern in all mammals studied which corresponds closely to that in man. Variations of lobes and lobules from the human type which are present in the usual experimental animals are related to the sensory and motor equipment of individual species and to the relative amount of cerebral cortex they possess. Cerebellar terminology is being modified to conform with the homologies which these studies have brought to light.

Subject: The relationship of specific groups of *E. Coli* to epidemic diarrhea of infants under the direction of Dr. Lyle Veazie.

Objectives: To determine the incidence of specific groups in such conditions. If etiological relationships can be established between these strains and the disease, it would make possible early and specific diagnosis and perhaps lead to a new approach to specific therapy.

Progress: Preliminary results indicate that such strains have been associated with at least one epidemic in this area in the past few years. Dr. Veazie is interested in receiving any material from such epidemics which may occur in this region so that further research may be possible.

Subject: Studies on the metabolism of Cholesterol and Ketone bodies with the aid of C^{14} Acetate under the direction of Dr. John Van Bruggen and Dr. E. S. West.

Objectives: To understand cholesterol and fatty acid formation and breakdown in the normal and diabetic state and investigation of the factors that may influence these reactions.

Progress: Cholesterol containing the carbon C^{14} has been prepared and its metabolism studied. Cholesterol carbon was found in the tissue fatty acids. Severe

fasting was found to decrease the amount of labeled acetic acid used for fatty acid and cholesterol synthesis, but such synthesis reactions are still active after fasting. Labeled acetic or ethyl alcohol is rapidly converted to fatty acids in cholesterol, a maximum being reached in two hours.

Subject: The significance of Rh antibodies in pregnancy under the direction of Dr. A. W. Frisch.

Objectives: To study at intervals during pregnancy serums from Rh negative women in an effort to determine the significant changes which occur during the process of isoimmunization, and to predict, if possible, the nature and extent of the disease in the fetus at term.

Progress: During a period of four years, approximately 150 cases of isoimmunization in pregnancy have been followed in the above manner, and a portion of these data have been published in the *American Journal of Clinical Pathology*.

Subject: Tuberculosis under the direction of Dr. A. W. Frisch.

Objectives: To determine the value of the simple media containing outdated human bank blood as a method for the diagnosis of tuberculosis and for assaying sensitivity of the organisms to streptomycin and other therapeutic agents.

Progress: Both of the above objectives have been achieved and it is now possible to isolate tubercle bacilli directly from sputums and other pathologic material using simple media containing 25 per cent human blood media of the type described in the January issue of the *American Journal of Clinical Pathology*. This simple medium is also suitable for sensitivity testing (to be published).

Subject: Tuberculosis under the direction of Dr. A. W. Frisch.

Objectives: To determine the factors in blood which are responsible for the growth of *M. tuberculosis*.

Progress: It has been found (to be published) that at least two components in blood are responsible for the growth of this organism, namely, intact washed red cells and plasma or serum. Regarding the red blood cells, it has been observed that the growth promoting substance is present in the contents and absent from the stroma of the red cell. The examination of the plasma has revealed that fractions I, IV, V and VI probably do not contain the growth factor. There is suggestive evidence, based on one successful experiment, that the growth promoting factor is present either in fractions II or III or both. Additional studies are in progress.

Subject: Chromogenic acid-fast bacilli under the direction of Dr. A. W. Frisch.

(Continued on Page 372)

**DISEASES OF THE CHEST**

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ROBERT J. CONDON, M.D.

JOHN D. WELCH, M.D.
Chief of Staff

LLOYD F. ECKMANN
Administrator



Objectives: To determine their potential pathogenicity.

Progress: Extensive studies completed on this group of organisms indicate that they occupy a position intermediate between true tubercle bacilli and saprophytic acid-fast organisms. Experiments to be reported deal with cultural characteristics, animal pathogenicity and sensitivity tests.

Subject: Effect of enzyme inhibitors on multiplication of viruses under the direction of Dr. A. W. Frisch.

Objectives: To study the metabolism and mode of formation of viruses.

Progress: Most of the experiments are confined to studies of the influenza group. A large number of enzyme inhibitors have been examined and none of these have significantly influenced the multiplication of the virus.

Subject: The production of bony lesions in chickens injected with leukemic blood under the direction of Dr. Arthur Frisch.

Objectives: To determine if the intravenous injection of leukemic blood into day-old chicks would produce lesions resembling the human disease over an observation period of approximately one year.

Progress: These studies have been completed and the results of the original investigator were not confirmed. There was no evidence of leukemia in chicks despite repeated X-rays, close examination and autopsy of representative groups of birds.

Subject: Poliomyelitis under the direction of Dr. A. W. Frisch.

Objectives: To propagate the MEF 1 virus in tissue culture.

Progress: Extensive studies to date have yielded only suggestive data but not definite results. This observation is in contrast to the ease in which other Lansing type viruses and human strains are grown in tissue culture.

Subject: Using a new type Sphygmograph-electrocardiograph to record on sensitized paper the pulse wave for studying the elasticity of the blood vessels under the direction of Dr. Norman David and Dr. Lennox Dick.

Objectives: Early diagnosis of atherosclerosis in early cases of diabetes.

Progress: Early results indicate an ability to aid in the diagnosis of cardiovascular problems.

Subject: Treatment for clinical cases of nausea and vomiting in patients due to anesthetics, pregnancy, drug reactions and abdominal disorders—a cooperative effort with physicians of Portland and Drs. Elton McCawley, Richard Kulasavage, Rich Warrington and T. Pasquesi.

Objectives: Developing a new use of Benadryl.

Progress: Ready for publication. Over 80 cases have been studied.

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PHOSPHALJEL quickly relieves pain and promotes healing. Excellent for oral therapy, and for intragastric drip therapy.



1. Fauley, G. B., Freeman, S., Ivy, A. C., Atkinson, A. J., and Wigodsky, H. S.: *Arch. Int. Med.* 67:653, 1941.
2. Upham, R., and Chaikin, N. W.: *Rev. Gastroenterol.* 10:287, 1943.
3. Collins, E. N.: *J. A. M. A.* 127:890, 1945.

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(1) Mann, G. V., and Stare, F. J.: Nutritional Needs in Illness and Disease, J.A.M.A. 142:409 (Feb. 11) 1950.

(2) Stieglitz, E. J.: Hypertensive Arterial Disease and Hypotension, Chapter 30, Geriatric Medicine, The Care of the Aging and the Aged, 2nd ed., Philadelphia, W. B. Saunders Company, 1949.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

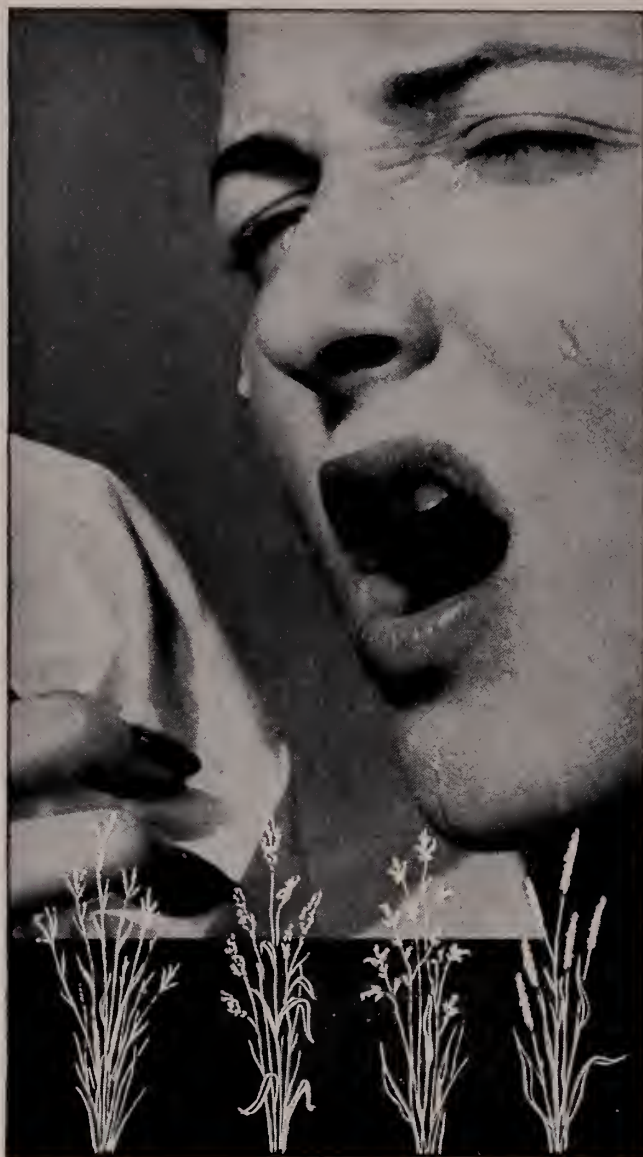


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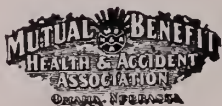
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Gray, L.: J. Clin. Endocrinol. 3:92 (Feb.) 1943.

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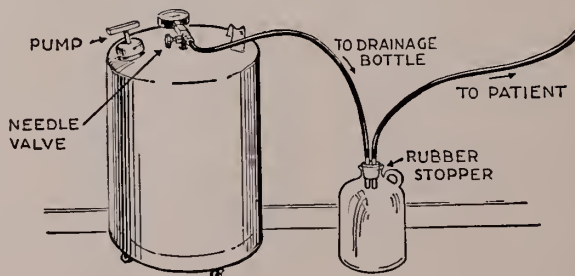
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Diagram at right illustrates tap of tank with vacuum gauge reading in inches of mercury, a needle valve and pump handle. There is also a handle for ease of moving when required. In juxtaposition to the gauge is a conduit to which rubber tubing is connected, leading to the drainage bottle and then to the patient.



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Chlor-Trimeton*
maleate tablets
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Chlor-Trimeton Maleate is available in 4 mg. tablets.

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DESOXYN[®] Hydrochloride

(METHAMPHETAMINE HYDROCHLORIDE, ABBOTT)

TABLETS

2.5 and 5 mg.

ELIXIR

2.5 mg. per fluidrachm
20 mg. per fluidounce

AMPOULES

20 mg. per cc.

For low-calorie
diets, suggest

SUCARYL[®]

Abbott's new heat-stable,
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Gardner, Butler, et al., state: "Relative to human milk, cow's milk has a low Ca:P ratio..."¹ Nesbit writes: "Tetany of the newborn is now recognized as a definite entity... and often accompanied by an increased phosphorus and lowered blood calcium."² Dodd comments that "hypocalcemia tetany in the newborn may be of serious consequence."³

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But an adjusted Ca:P ratio is not the only attribute that makes Bremil new and unique

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Complete information and a trial supply may be obtained upon request. BREMIL is available in drugstores in 1 lb. cans.

1. Gardner, L. I., Butler, A. M., et al.: *Pediatrics* 5:228, 1950.

2. Nesbit, H. T.: *Texas State J. M.* 38:551, 1943.

3. Dodd, K., and Rapoport, S.: *Am. J. Dis. Children* 78:537, 1949.

4. Recommended Daily Dietary Allowances, Revised 1948, Food and Nutrition Board, National Research Council.

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palatable, easy to prepare **Bremil**® powdered infant food



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Clark County Society President, D. R. Laree Vancouver	First Tuesday—Vancouver Secretary, F. M. Butler Vancouver
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Groves Harbor County Society President, F. J. Dwyer Aberdeen	Third Wednesday—Aberdeen Secretary, L. Semler Haquiam
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King County Society President, D. Metheny Seattle	First Monday—Seattle Secretary, F. A. Tucker Seattle
Kitsop County Society President, H. A. Barner Bremerton	Second Monday—Bremerton Secretary, F. Rosendale Bremerton
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Klickitat County Society President, J. R. Rehal Stevenson	Secretary, D. G. Moody White Salmon
Lewis County Society President, Robert Fulton Chehalis	Second Monday—Centralia and Chehalis Secretary, Rush Banks Centralia
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Pierce County Society President, J. F. Steele Tacama	Second Tuesday—Tocoma Secretary, G. C. Kahl Tacama
Skagit County Society President, R. R. Rueb Concrete	Fourth Monday Secretary, R. Hoag Concrete
Snohomish County Society President, J. Meeske Snohomish	First Thursday—Everett Secretary, R. J. Wescott Everett
Spokane County Society President, R. D. Reekie Spokane	Second Thursday—Spokane Secretary, G. T. Wallace Spokane
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Thurston-Mason Counties Society President, R. Highmiller Olympia	Fourth Tuesday—Olympio Secretary, H. B. Frank Shelton
Walla Walla Valley Society President, M. W. Tompkins Walla Walla	Second Thursday—Walla Walla Secretary, L. O. Carlson Walla Walla
Whatcom County Society President, A. G. Zoet Bellingham	First Monday—Bellingham Secretary, P. E. Rowe Lynden
Whitman County Society President, M. K. Turner Pullman	Third Wednesday—Calfox Secretary, W. S. Butts Pullman
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ANNUAL SOCIETY MEETINGS

- American Medical Association**.....Atlantic City, June 11-15, 1951
Oregon State Medical Society.....Portland, Oct. 10-13, 1951
President, W. J. Weese Secretary, R. F. Miller
Ontario Portland
- Washington State Medical Association**.....Seattle—Sept. 9-12, 1951
President, K. L. Partlow Secretary, J. W. Haviland
Olympia Seattle
- Idaho State Medical Association**.....Sun Valley—June 17-20, 1951
President, R. T. Scott Secretary, R. S. McKean
Lewiston Boise
- Alaska Territorial Medical Association,**
Ketchikan—May 31-June 2, 1951
President, D. Cramer Secretary, W. P. Blanton
Ketchikan Juneau

PERIODICAL SOCIETY MEETINGS

NORTHWEST

- North Pacific Orthopedic Society**.....Sun Valley—May, 1951
Secretary, J. K. Burton President, W. H. Goering
Boise Tacoma
- North Pacific Surgical Assn.**...Vancouver, B. C., Nov. 16-17, 1951
President, S. F. Herrmann Secretary, J. A. Duncan
Tacoma Seattle

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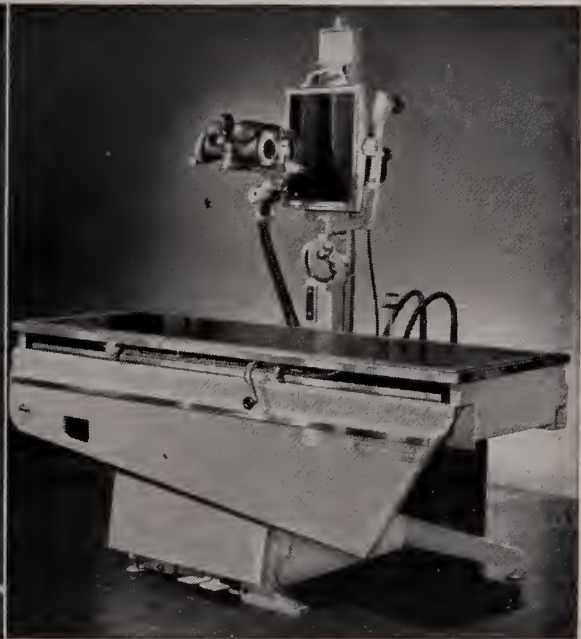
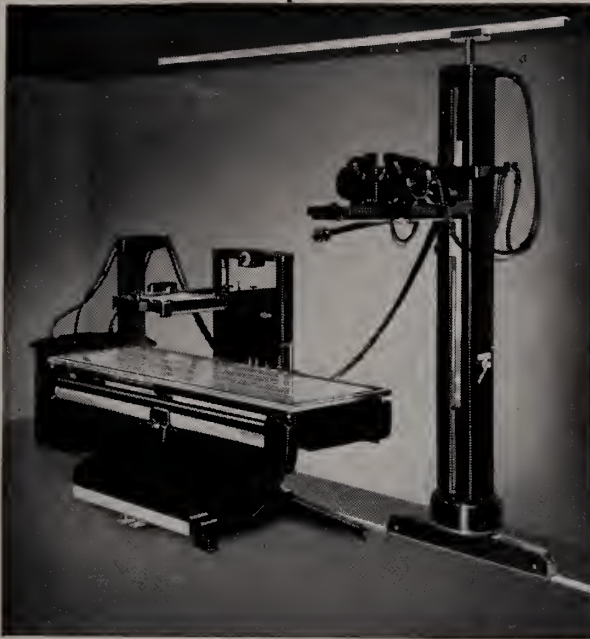
- Central Willamette Society**.....Second Thursday
President, W. W. Ball Secretary, F. R. Asbury
Corvallis Corvallis
- Oregon Academy of Ophthalmology and Otolaryngology**—Third Tuesday, Old Heathman Hotel, Portland
President, R. S. Fixott Secretary, G. E. Chamberlain
Portland Portland
- Oregon Pathologists Association, Second Wednesday**—Portland
President, V. D. Sneeden Secretary, J. E. Nohlgren
Portland Portland
- Oregon Radiological Society**—Second Wednesday—University Club, Portland
Secretary, C. T. Jessell
Portland
- Portland Academy of Pediatrics**.....First Monday
President, S. G. Babson Secretary, Edward Rector
Portland Portland
- Portland Surgical Society**.....Last Tuesday
President, J. M. Roberts Secretary, J. W. Nadal
Portland Portland
- Southern Oregon Society**.....May, 1951—Klamath Falls
President, H. B. Currin Secretary, F. C. Adams
Klamath Falls Klamath Falls

WASHINGTON

- Puget Sound Academy of Ophthalmology and Otolaryngology**
.....Third Tuesday—Seattle or Tacoma
President, J. F. Tolan Secretary, Willard Goff
Seattle Seattle
- Seattle Academy of Surgery**.....Third Friday
President, J. C. Bennett Secretary, D. A. Huckaby
Seattle Seattle
- Seattle Gynecological Society**.....Third Wednesday
President, C. D. Kimball Secretary, Robert Plant
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- Seattle Pediatric Society**.....Fourth Friday
President, W. A. Jaquette Secretary, G. E. M. Adkins
Seattle Seattle
- Seattle Psychoanalytic Study Group**.....First Thursday
President, Gert Heilbrunn Secretary, E. W. Haertig
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- Seattle Surgical Society**.....Second Friday
President, J. A. Duncan Secretary, R. B. Hearne
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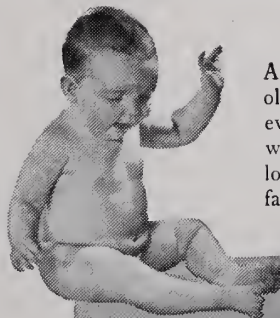


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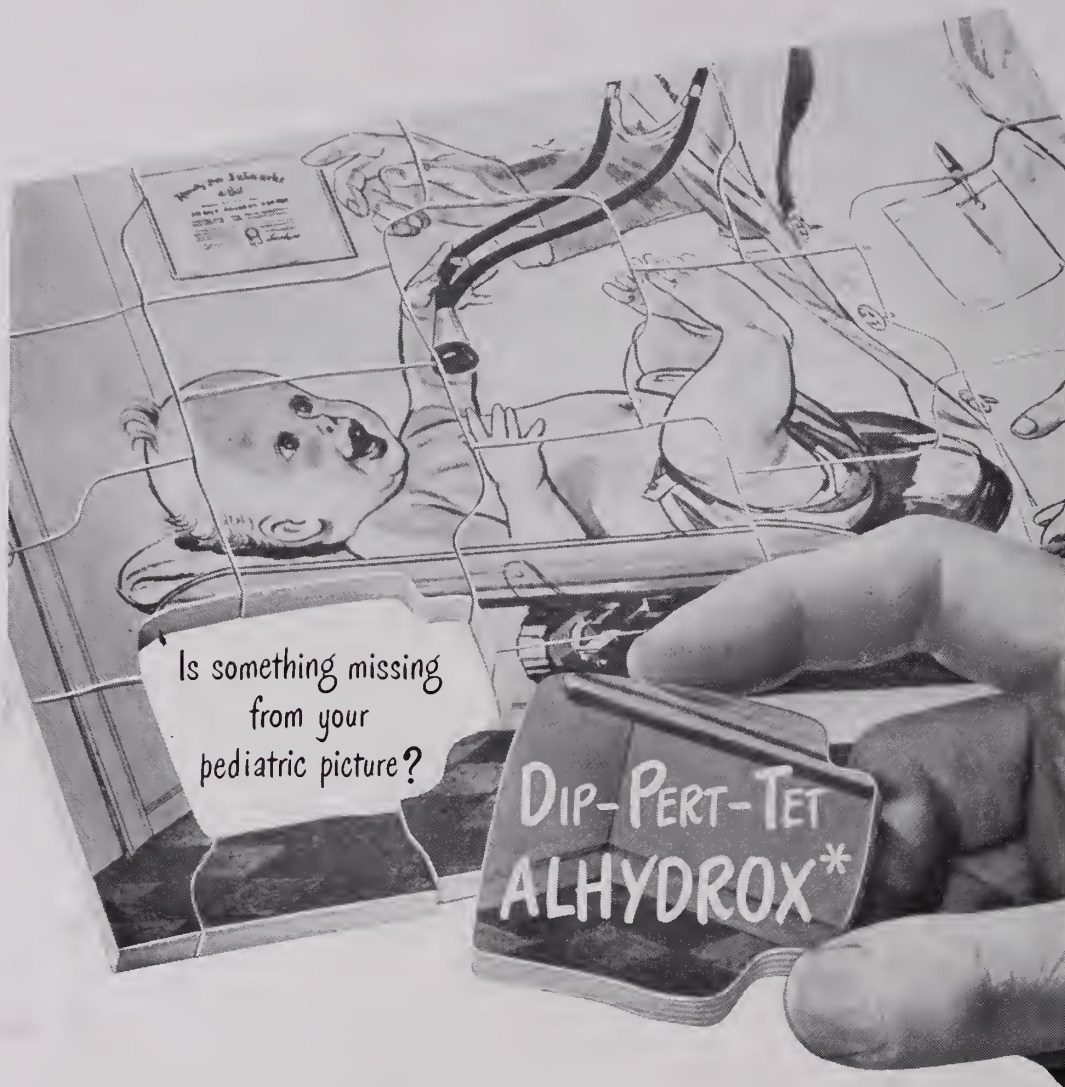
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JUNE, 1951

No. 6

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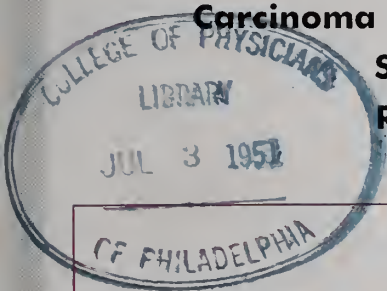
Acute Poliomyelitis—Maxwell, Muenster and Polley

Carcinoma of Fallopian Tube—Forbes and Finlayson

Sunburn Prevention—Hemphill

Reservation Notice—Page 440

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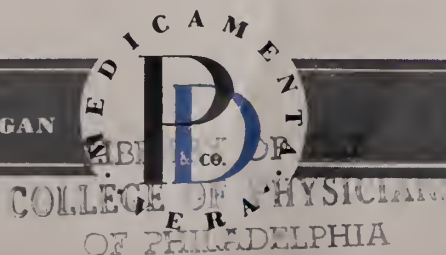
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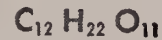
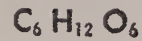
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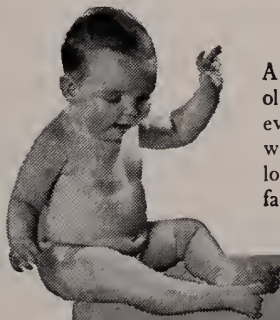


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Cow's milk—Dextri-Maltose® formulas, successful for 40 years, provide optimum amounts of protein, fat and carbohydrate. In accordance with recommendations of authorities, approximately 15% of the calories are supplied by protein, 35% by fat, 50% by carbohydrate.



A typical formula for a 4-month-old infant would consist of 12 oz. evaporated milk, 20 oz. boiled water, 6 tbsp. Dextri-Maltose. Caloric distribution: protein, 15%; fat, 39%; carbohydrate, 46%.

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FACTUAL
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SUCARYL®

(CYCLAMATE, ABBOTT)

the new heat-stable, non-caloric sweetener

WHAT IT IS: SUCARYL is a new non-caloric sweetening agent useful in the preparation of sugar-restricted diets for diabetic and obese patients. Its function is to supply the desired sweetness without adding carbohydrate, thereby making it easier for patients to adhere to a strict dietary regimen. SUCARYL is heat-stable, which permits its use in boiling, baking, canning and freezing processes without loss of sweetness. As a result, SUCARYL can be used in a great variety of foods. It has a sugar-like sweetness and leaves no bitter or metallic aftertaste in ordinary use.

HOW SUPPLIED: Now in calcium as well as sodium forms. Handy-to-carry SUCARYL Sodium tablets, eighth-gram, effervescent, grooved, in bottles of 100 and 1000; SUCARYL Sodium Sweetening Solution, liquid form convenient for household use, in 4-fluidounce bottles; and SUCARYL Calcium Sweetening Solution, newly developed non-sodium form for low-salt diets, in 4-fluidounce bottles.

RECOMMENDED USAGE: Recommended daily limit for adults, 12 tablets or about 1½ teaspoonfuls of solution. Since the tablets contain sodium bicarbonate as a disintegrator, somewhat lower sodium diets are possible with the sodium solution than with the tablets. Sodium content per tablet is 21.64 mg., while an equivalent amount of sodium solution contains 14.25 mg.

Patients on strict low-salt diets, however, should use the calcium solution. The calcium form has a lower bitter taste threshold, noticeable in some foods when the proportion reaches 0.5 percent, compared to about 0.8 percent for the sodium form. Both forms are equally good in ordinary use.

NEW, ENLARGED RECIPE BOOKLET is now available. Contains canning and freezing instructions, plus new recipes for cooked and baked foods sweetened with SUCARYL. Recipes save 15 percent or more in calories. To obtain copies for your patients, see your Abbott representative, or simply write "SUCARYL Recipe Booklets," specifying the number you need, on your prescription blank and mail to Abbott Laboratories, North Chicago, Illinois. Professional literature and a sample bottle of SUCARYL Sodium tablets also will be sent on request.

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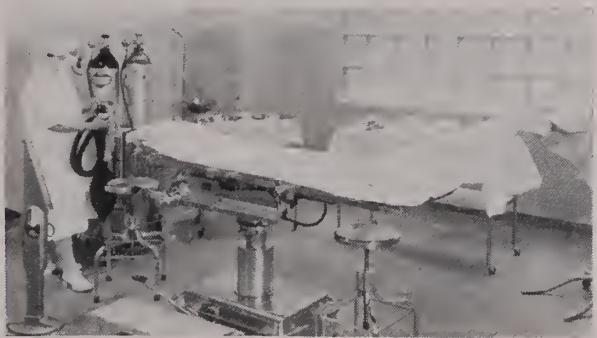
That's where your money goes. For the fiscal year 1951 the Public Health Service is dishing out \$119,-315,500.00 to the states for public health services. Oregon gets \$1,238,697.00, Washington \$1,486,429.00, Idaho \$537,744.00, Alaska \$404,000.00. But that is not all. For maternal and child welfare this year there is an additional disbursement of \$33,328,724.00. Next year a bit more will be thrown around if a certain house bill gets by the senate. This one adds up to \$210,805,000.00. It only covers 1952 expenditures for hospital construction, hospital and medical care for seamen and Coast Guard, National Institute of Health, mental health activities, National Cancer Institute, dental health activities, construction of research facilities, communicable disease, miscellaneous venereal disease programs, miscellaneous programs in field TB, environmental sanitation and industrial hygiene and vocational rehabilitation. Isn't it wonderful how much better use is made of our money after it passes through the hands of the experts in Washington? Of course it is getting a little bit old-fashioned to talk about just millions but it is still a pretty neat stack of chips. Especially nice to think about when you write that June 15 check.

Residencies in approved hospitals are listed by the Council on Medical Education and Hospitals. Any physician may have the list by requesting it. The list is revised each month according to data received from hospitals. Hospitals desiring to be listed or individuals seeking information on residencies currently available should write to: Residency Information Service, Council on Medical Education and Hospitals, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Lilly Research Laboratories announce a new anti-thyroid drug, Tapazole. It is 1-methyl-2-mercaptoimidazole (Methimazole). It is the most potent anti-thyroid drug known. It will control hyperthyroids refractory to the thiouracil group. It also acts more quickly. Dose is from 5 to 10 mg Q8H. Larger doses are not harmful but are usually not necessary. Side effects are about the same as those of propylthiouracil.

Intravenous use of procaine has become more and more popular. Now J. S. Horan of Memphis reports on intravenous use of pontocaine. Paper is in the *Journal of the Tennessee State Medical Association* for April. He claims good results in about 96 per cent of those treated.

Mercurial diuretic made safe by BAL principle announced by Wyeth. The new drug is not painful in tissues and is somewhat slower acting than others in



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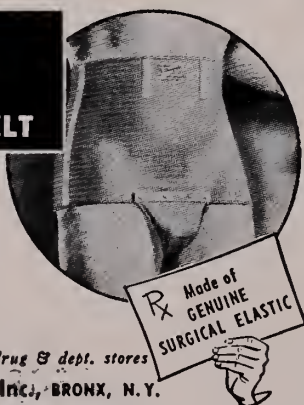
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the group. Most of the recently introduced mercurials have been rendered non-irritating by combining theophylline-like materials with mercury. The new Wyeth product called *thiomerin* has been detoxified by a mercaptan. This is an SH group of which BAL has two. Thiomerin has only one such group. Therefore it is sometimes described as a half BAL.

The new drug acts more slowly at first but 24-hour diuresis is said to equal other mercurials. Since it does not irritate, even in subcutaneous tissue it seems safe for administration in the home by relatively untrained personnel.

A cross country airplane trip does something to you. Breakfast in Seattle—dinner in Chicago—really astounding if you don't just take it for granted. Far below unrolls the great fabric of a great country. Green mountains of Washington, alternate strips of wheat fields and fallow soil in Montana—and scarred and ugly face of Mother Earth so aptly called the Badlands. Three hours and fifty-one minutes out of Spokane your wheels are on the field at Minneapolis.

From the air, the Land O'Lakes looks like nothing more than a great flat area on which the rain has recently fallen—the puddles have not all dried up yet. Further south come the regular rectangles of a land completely cultivated. Some are rich deep green—others show the solid black of fertile midwest soil.

Then out of the haze looms Chicago. Big, busy, boisterous, the city somehow symbolizes America. A vast aggregation of restless humans, all hurrying somewhere—working—playing—dreaming—building—doing—going. The city by Lake Michigan never rests—neither does America. It is not always a happy city—neither are we as people. But it goes forward, indomitable, higher with its skyscrapers, wider with its sprawling suburbs. Truly it represents the restless driving force of America—never content with the past—always with plans for the future. A great and stimulating city, a huge and interesting country. It is a great privilege to be a part of it and to enjoy its benefits. Especially to sit about for a few hours and look it over. Seeing it from 17,000 feet does something to you that doesn't seem to happen on the ground.

Unger and Unger of Chicago report on a sublingual method of controlling migraine in the *Illinois Medical Journal* for April. They use a tablet of ergotamine tartrate, acetyl-salicylic acid, caffeine and saccharin. Series reported is too small to provide a valid answer but work is still in progress. Results come more quickly than by other methods and in some cases the treatment provides better relief than by any other method.

Hyaluronidase was kicked around the research laboratories for a long time before it grew up enough to take a part in clinical medicine. Now another place for it has been found. Byrne and Melick of St. Louis use it for subcutaneous urography. They use 70 per cent urokon which is put into an area which has been infiltrated with hyaluronidase. The article is in *Urologic and Cutaneous Review* for April.

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Casualty Lines Will Be Added Shortly

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sincerely thank the medical men of the state who individually, and in groups, contributed so generously to the financing of the company through the purchase of capital shares.

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INSURANCE CO. GETS GO-AHEAD

Washington's newest insurance company, the Western Pacific Insurance Co., got the official go-ahead Wednesday with issuance of a state certificate of authority.

Don C. Burnam, president, said the new company will operate initially in Washington only, but plans to enter Oregon and Idaho in the near future. Only fire and allied insurance is being written at the present, he said.

Boyce Stanard, former manager of a large fire insurance firm here, is vice president of Western Pacific.

Directors, besides Burnam, include Dr. William Bowen, Tacoma; Dr. Donald G. Corbett, Spokane; and Dr. A. J. Bowles, Dr. Norman W. Clein, William H. Ferguson, Al Hughbanks, Ival L. Hyland, George W. LaFray, Roscoe C. Torrance, Ralph H. Wayland and Shirley Boyd Williams, all of Seattle.

The new firm has an authorized capital and surplus of \$700,000, and is beginning operations with \$400,000 of that paid in, Burnam said.

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For children, palatable Elixir Dorsaphyllin is acceptable and well tolerated. For the hypersensitive, Dorsaphyllin Suppositories are available.

Fram The Literature

- Bubert and Cook, Bulletin of School of Medicine, Univ. of Maryland, Vol. 32, pp. 175-190, 1948.
- Paul and Montgomery, J. Iowa State Med. Soc., June, 1948.
- Krantz, Holbert, Iwamoto and Carr, J.A.Ph.A., Vol. 36, pp. 248-250, 1947.
- New and Non-official Remedies, 1950, p. 285.



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Convenient OFFICE Pregnancy Diagnosis within 60 minutes

THE Q-TEST

PROVED 95% RELIABLE

Ten fruitful, clinical years have passed since Frederick H. Falls, M.D., Vincent C. Freda, M.D., and Harold H. Cohen, M.S. (1) first described the use of primiparaus colostrum in skin tests for pregnancy diagnosis. Yet initial impact seems to increase as current studies culminate in clinical conclusions based on the use of Q-Test with the Ogle Micro-dispenser.

One such report, typifying others soon to be published, is furnished by Nina Ferrera, M.D. (2). His evaluation is based on extensive clinical use of the Q-Test at the Woman's Hospital, Pasadena, where it was proved 95% to 98% accurate.

That the fallibility of pregnancy diagnosis approaches the optimum zero percentile through the Q-Test is emphasized in all the reports of recent clinical observations.

ACCURACY: 95% according to recent clinical studies. **SPEED:**

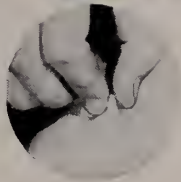
Intradermal injection can be made in a few seconds; results apparent in 30 to 60 minutes. **CONVENIENCE:** The Q-Test is a complete unit requiring no special equipment, chemicals or bottles, and can be performed right in the physician's office.

PATIENT REACTION: Enthusiastic, since results can be known at the first office visit.

ECONOMY: Cost per test considerably lower than other pregnancy tests requiring laboratory analysis.

Convenient to Use

TOP—Ogle Micro-dispenser: A is fin by which it is grasped between thumb and forefinger; B is flexible bulb containing colostrum solution; C is needle protector cap. BOTTOM—shows dispenser where needle has entered skin, and bulb B is being squeezed.



Complete illustrated instructions enclosed with each Q-Test.

(1) American Journal of Obstetrics and Gynecology, March 1941 (2) Ibid., March 1951

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*Keep him active
... longer
with plenty of citrus fruit*

As at the other end of the age gamut, optimal nutrition can make a tremendous difference in the vigor and stamina of the oldster.^{1,6,8-11} Many geriatricians stress the importance of vitamin C in the management of geriatric diets,^{2,5,9} and recommend a fully adequate intake^{5,9} of citrus fruits and juices (so often neglected by older people)—because of their high content of this essential vitamin and of other nutrients. Fortunately most everyone likes the taste of Florida citrus fruits and juices. They may be served in a variety of ways, and—under modern techniques of processing and storage, whether fresh, canned or frozen—they can *retain their ascorbic acid content*,^{3,7} and their *pleasing flavor*,⁴ in very high degree and over long periods.

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References:

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(brand of propenpyridamine)

TRIMETON—indicated in all allergic states responding to antihistamines.

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AN IMPORTANT FACTOR IN OLD AGE

A RECENT study¹ of the health and nutritional status of 200 elderly patients and their dietary habits revealed their food intake to be deficient in iron, calcium, protein, and, particularly, B complex vitamins. In many instances the lassitude and premature weakness of the elderly are due to such deficiencies.

Correction by increased intake of ordinarily eaten foods often proves difficult. The quantities that would have to be eaten frequently are more than the individual can consume comfortably.

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The nutritional contribution of three servings of Ovaltine in milk (the recommended daily amount) is defined in the appended table.

1. Bortz, E. L.: Management of Elderly Patients, Postgraduate Med. 3:186 (Mar.) 1950.

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COPPER	0.5 mg.	CALORIES	676

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.

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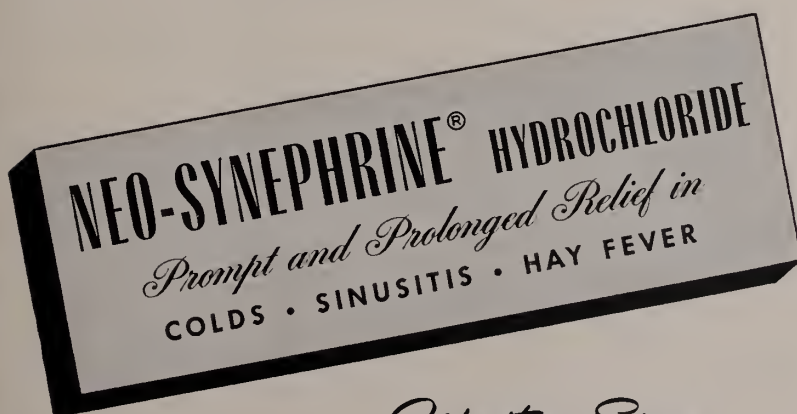
"When considerable nasal obstruction exists, relief may be obtained by the instillation of some shrinking agent into the nose... as for example Neo-Synephrine hydrochloride ($\frac{1}{4}\%$)"¹

A "desirable preparation of this type has been perfected in Neo-Synephrine hydrochloride. It may be used for local application in the nose in $\frac{1}{4}$ to 1% solution."²

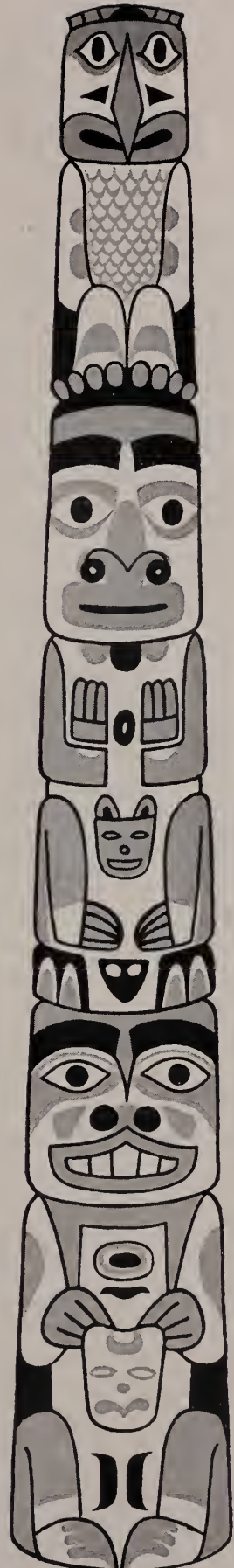
Neo-Synephrine's "desired effect occurs within from two to fifteen minutes..."³

"Its action is sustained for two hours or more."³

Neo-Synephrine hydrochloride is notable for freedom from sting and for effectiveness on repeated application. There are few complaints of after effects such as burning and nasal congestion... and little tendency to develop local sensitivity.¹



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2. Hansel, F. K.: Allergy of the Nose and Paranasal Sinuses. St. Louis, C. V. Mosby Co., 1936, p. 769.

3. Kelley, S. F.: Choice of Sympathomimetic Amines. Cornell Conferences on Therapy, II, 1947, p. 156.

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that propionate-caprylate treatment is eminently effective...None of the patients complained of irritation and there was no evidence of sensitization. On the contrary, pre-existing 'id' areas disappeared during treatment."²

1. Nettleship, A.: Arch. Dermat. & Syph. 61:669, 1950

2. Brewer, W. C.: Arch. Dermat. & Syph. 61:681, 1950

Sopronol therapy is a therapy of choice with physician after physician.



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SOLUTION

Sodium propionate	12.3%
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NORTHWEST MEDICINE

VOL. 50, No. 6

JUNE, 1951

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EDITORIALS

Surgical Standards and General Practice

The rapid revival of interest in general practice in this country has had some significant side effects. Among these is the alarm which has arisen in certain specialist groups lest the public be endangered by lowering of standards. One of the most articulate expressions of this alarm recently published is the letter by Edwin P. Lehman, M. D., Director, Dept. of Surgery, University of Virginia, in the correspondence department of the Journal of the American Medical Association, May 19. The letter is a kindly criticism of the current trend and is written with obvious sincerity. Dr. Lehman is truly disturbed by what he sees. He says so honestly and with well chosen words.

There is just a little doubt, however, as to whether he sees the whole picture. Or whether perhaps he has seen it in quite the proper light. He seems to see a world in which there is no longer a need for the term *general practice*. He looks upon surgery by general practitioners and finds it not to his liking.

Certainly this cannot be the view of the vast majority of physicians in this country. Indeed it would not be, for the vast majority are avowed general practitioners. But even among specialists there is a substantial number to take issue with Dr. Lehman. Many specialists really have the philosophy of general practice at heart. Far from being obsolete the term *general practice* is not only here to stay—it is growing. It grows, not only in the number of devotees, but in its very meaning. If Dr. Lehman still harbors any doubts as to the vitality of the term and its attractiveness to young men let him make a survey. Let him canvass upper class medical students, not only in his own school but across the country. Then let him compare his figures with those taken as recently as five years ago. He may be amazed to learn of the numbers who now prefer the broad interests of general practice to the confines of narrow specialism.

Dr. Lehman fears a lowering of standards if the interest in general practice continues to grow. In this he is not alone. Others have expressed the

same view both in private and also where their words have had a great deal to do with the practice of medicine in this country.

It would be simple to categorically deny that these fears are unfounded. Such a statement, however, would be neither useful nor convincing. There are innumerable facts which speak emphatically for the constantly improving standards of general practice. And, as general practice improves, so improves, in the large sense, the service which American medicine renders to the public.

If Dr. Lehman has not previously been aware of one of these facts let him look up the requirements for membership in one of the general practice groups. It is not likely that even those splendid surgical organizations to which he belongs place such stringent study requirements upon their members.

Another fact about which Dr. Lehman might like to hear concerns something which happened at a west coast hospital. The occurrence was local but the attitudes expressed by participants undoubtedly reflect those held across the nation.

A group of men practising a specialty were concerned over errors being committed in their field by a few general practitioners. They formulated a set of rules. Since they did not wish to offend anyone they did not publish their regulations but had them approved by the hospital superintendent and the medical board. It was intended that they be used only to control those whose training and ability in the given field were found to be inadequate. Inevitably, however, the rules were brought out when one of the most able general practitioners of the community committed an infraction late one night. Considerable argument ensued. It finally culminated in a meeting which included the superintendent, the medical board, the specialist group and representatives of the general practitioners of the community.

There was immediate and unquestioned unanimity of opinion that the highest possible standards of service to the public should prevail in the hos-

pital. The only difference expressed was in the methods proposed to attain them. The specialists preferred a set of rules. The general practice group opposed this. They cited the serious difficulty in formulating hard and fast rules to cover a field in which circumstance could alter conditions so widely. They preferred to eliminate written rules. They wished to rely on the honesty and integrity of the individual to conduct himself in accord with established custom, to practice according to accepted standards and to perform only those procedures for which he was qualified.

Sharpest disagreement, however, arose over

methods of enforcement. The general practice group stated emphatically that a physician not meeting the requirements outlined above should be denied staff privileges at that hospital. The specialist group demurred. None was willing to be the one to swing the axe.

In view of such events and in the light of so many other facts constantly coming to light it seems only reasonable to ask Dr. Lehman to take another look at the picture. Perhaps he may find the standards of general practitioners across the country considerably higher than he thought when he wrote his excellent letter.

Status of Unregistered Doctors Clarified

Misinterpretation or improper advice resulted in the failure of some Northwest doctors, dentists and veterinarians to register at either of the Special Registrations, as required by the Selective Service Act.

To clarify this question, the Washington State Selective Service Office has definitely outlined in the following letter the requirements of the Selective Service Act. All physicians, dentists and veterinarians under the age of 50 who have not registered should read this letter carefully, and if they should have registered and did not, they can still do so at their local Selective Service Board.

Dr. Alfred O. Adams, Chairman
Volunteer Washington State Advisory Committee
852 Paulsen Medical-Dental Building
Spokane 8, Washington

Dear Mr. Adams:

With reference to the question "Who is required to register under Special Registration No. 1," which was discussed at some length during the meeting of the Advisory Committees in Seattle on May 4, 1951, the following information is furnished:

In the President's Proclamation for the Special Registration, it is stated: "1. Every male person who participated as a student in the Army specialized training program or any similar program administered by the Navy, or was deferred from service during World War II for the purpose of pursuing a course of instruction leading to education in a medical, dental or allied specialist category and has had less than twenty-one months of active duty in the Army, the Air Force, the Navy, the Marine Corps, the Coast Guard, or the Public Health Service subsequent to the completion of, or release from, such program or course of instruction (exclusive of time spent in post-graduate training), and who, on the day or any of the days hereinafter fixed for his registration (a) shall have received from any school, college, university, or similar institution of learning one or more of the

degrees of bachelor of medicine, doctor of medicine, doctor of dental surgery, doctor of medical dentistry, doctor of veterinary surgery, and doctor of veterinary medicine, (b) is within any of the several States of the United States, the District of Columbia, the Territory of Alaska, the Territory of Hawaii, Puerto Rico, or the Virgin Islands, (c) *is not a member of any reserve component of the Armed Forces of the United States, (italics added)* and (d) shall not have attained the fiftieth anniversary of the day of his birth is required to and shall on that day or any of those days present himself for and submit to registration before a duly designated registration official or selective service local board having jurisdiction in the area in which he has his permanent home or in which he may happen to be on that day or any of those days."

You will note that in paragraph 1(c) no requirement is made as to whether the registrant is a member of an active or inactive reserve component.

The term "reserve component" is defined in Section 16(i) of the Selective Service Act of 1948, as Amended, which states that "The term 'reserve components of the Armed Forces' shall, unless the context otherwise requires, be deemed to include the federally recognized National Guard of the United States, the Officers' Reserve Corps, the Regular Army Reserve, the Air Force Reserve, the Enlisted Reserve Corps, the Naval Reserve, the Marine Corps Reserve, and the Coast Guard Reserve, and shall include, in addition to the foregoing, the Public Health Service Reserve when serving with the Armed Forces."

You will note that the Army of the United States is not included in the definition given for "reserve components of the Armed forces."

It is the opinion of this Headquarters that Special Registrants who have AUS commissions and who are not members of any of the reserve components listed above, are required to register.

For the State Director,

D. J. MANSFIELD

Captain, AGC

Quotas and Calls Officer.

In Memoriam

HARRY ROBERTS CLIFF

M. D.



UNHERALDED and unsung, a life of service, private and public, stricken at an advanced age, is snuffed out, marking the departure of a beloved colleague, Dr. Harry R. Cliff, not far from his ninety-fourth birthday. Not unexpected by those who saw him languish following a stroke four years ago, his many friends are nonetheless grieved at the loss of a rare spirit in our profession.

Dr. Cliff was born in England and after local primary and secondary school, pursued medical study at London School of Medicine and went to Australia at an early age, took further work at the University of Melbourne and became a medical officer in the Australian Navy. He emigrated to the United States and settled in St. Helens, Oregon, in 1885, and was soon plunged into the picturesque and arduous medical practice of the period, to which he lent lustre by generous competent service and unswerving fidelity to his patients for twenty-five years.

A picture of Dr. Cliff, attired in high silk hat and Prince Albert coat, erect on horseback in town practice, contrast with one in which he is equipped with bilateral saddlebags enroute to a call far into the forest, then being logged by oxen, suggesting the rugged nature of the doctor's life in an era before the electric current, telephone, paved roads, automobile, hospital facility, "wonder drugs," office secretary and "hours by appointment only." Mangled complicated fractures he wisely amputated on the spot under chloroform, thus saving life that would be threatened by transportation and as Dr. Cliff said, "reintroduction to the infections of town practice." According to him, "there is no infection in the woods," so it was not necessary to see the patient again until he came in three or four weeks later "to talk about a peg leg."

He was elected Mayor of St. Helens and civic pride inspired his interest in iron ore in the hills thereabout

to his sad financial loss. He came to Portland in 1910 and associated in practice with the late Dr. Edward P. Geary, Multnomah County Health Officer, whom he succeeded, thus becoming responsible for sanitation and health, Superintendent of the County Infirmary and Director of Multnomah County Hospital. In the latter, particularly, he distinguished himself, to the public's benefit, by the planning and construction of the first modern county hospital in the state and operating it, in his navy parlance, "shipshape." Most important of all was his advanced concept of the responsibility of the hospital to the patient and to the training of future doctors. Hence, much through his influence, the hospital was built upon the campus of the University of Oregon Medical School and affiliated with the latter in a manner that became a national example of the expediency and wisdom of cooperation between state and county political units in a program of research, medical education and the most effective care of the sick and injured. His was a large role in the development of the Medical Center in Portland.

But what will be cherished most by his friends in practice and in the faculty, by the many doctors who served as interns under his direction, and by the employees of the hospital and innumerable patients is the memory of the sweet simplicity and humility of the man, qualities so often associated with greatness. His was no nature that could harbor ill will or nurse a grudge. He was utterly unselfish. But he was strong and could be stern, preferring, however, to attain objectives not by domination or coercion, but by a posture of gentility that inspired respect, loyalty and devotion. The community owes his memory much. His life was an embellishment of his profession and a credit to the craft.

RICHARD B. DILLEHUNT,
Dean Emeritus,
University of Oregon Medical School.

ORIGINAL ARTICLES

Infantile Cortical Hyperostosis with Involvement of Ilium*

CLAY A. RACELY, M.D.

EUGENE, ORE.

JOSEPH B. BILDERBACK, M.D. and WILLIAM Y. BURTON, M.D.

PORTLAND, ORE.

MANY excellent papers on infantile cortical hyperostosis have been published in the pediatric and radiologic literature since the original reports in 1945 by Caffey¹ and in 1946 by Smyth, Potter and Silverman.² Reported cases now total some thirty-seven.¹⁻¹² Caffey¹³ believes four of these in the older age group were in reality due to vitamin A poisoning, a condition described by Toomey and Morissette¹⁴ and Rothman and Leon.¹⁵ It was felt desirable to add our experiences with four additional cases seen at Doernbecher Memorial Hospital for Children in the past three years, to emphasize the differentiation from more serious conditions which may produce somewhat similar roentgen changes. Two cases show changes in the ilium not previously reported.

Infantile cortical hyperostosis is a relatively rare condition of unknown etiology, characterized by periosteal or cortical hyperplasia of multiple bones in the infant skeleton. It is self-limiting and entirely benign. The syndrome was so named by Caffey

because of the age incidence and the biopsy picture of hyperplasia of lamellar cortical bone without subperiosteal hemorrhage to account for periosteal elevation. Biopsies by Dickson, et al.⁶ showed edema and inflammatory cell infiltration of overlying muscle. However, the roentgenographic appearance may simulate various other processes, namely, the nutritional deficiency states, scurvy and rickets which require specific therapeutic supplements; hypervitaminosis A, from prolonged administration of vitamin concentrates;^{14,15} inflammatory lesions which require specific drug therapy, as in osteomyelitis or syphilis; or malignancy, such as bone sarcoma which demands early radical treatment.

The typical clinical picture presents a moon-faced infant from four weeks to twelve months of age with fever, hyperirritability, anemia and upset feeding habits. The laboratory findings are leucocytosis, increased sedimentation rate and elevated alkaline phosphatase.^{1,2} The moon-faced appearance is due to brawny edema of the mandibular region and enlargement of the mandible itself which is demonstrated by roentgenograms (fig. 4). Tender, soft tissue swellings of the extremities or over the scapulae may be present before roentgenographic findings of bone changes are apparent. Roentgenographic findings include varying degrees of subperiosteal calcification of the midshaft of long bones, clavicles, scapulae or base of the skull and onion-skin tubular densities about the ribs. Pleural effusion may accompany rib involvement.¹ The clinical picture, plus these characteristic roentgenographic changes, is diagnostic. Symptoms usually persist for several months. The fever is not controlled by antibiotics or chemotherapy.⁷ The bone changes often increase or new lesions appear after symptoms subside and then gradually disappear in one to two years, depending on the degree of involvement.

CASE 1

This case emphasizes the problem of differentiation from lues and illustrates involvement of the ilium, not previously described.

L. T., an eight-week-old white female bottle-fed infant, was admitted to Doernbecher Memorial Hospital for Children on October 18, 1946, because of fever and nontender swelling about the eyes. Supplemental vitamins had been given prior to illness.

The mother had severe influenza at two months gestation and a marked smallpox vaccination reaction at five months gestation.

*From Department of Radiology and Pediatrics, Doernbecher Memorial Hospital for Children, University of Oregon Medical School Hospitals and Clinics, Portland, Ore.

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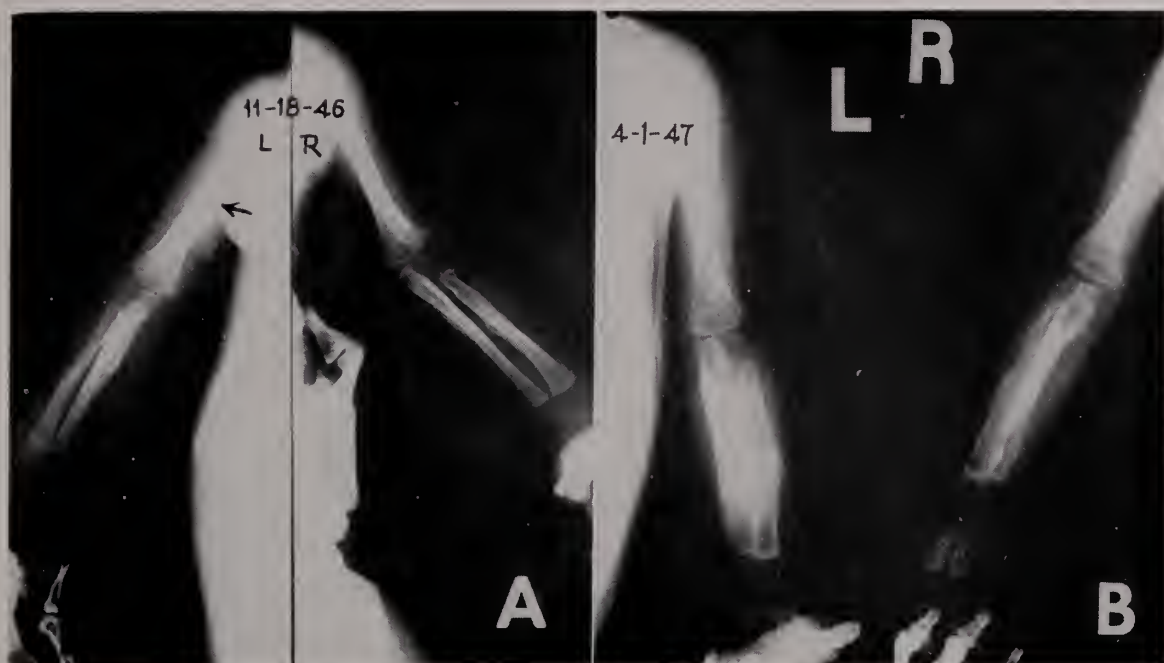


Fig. 1.—Case 1. White female. A: Age 3 months, 5 weeks after onset. Note periosteal proliferation of radii and left humerus and soft tissue density about left

humerus. B: Age 8 months, 5 months after onset. Note widening of shafts of radii and left ulna. The left humerus appears normal. Soft tissue swelling persists.

Present Illness: Parents first noticed swelling of the left upper eyelid on October 14. Their pediatrician found no other abnormalities. An ophthalmologist found no ocular disturbance and ENT examination, including sinus roentgenograms, was negative. The baby became fretful and took feedings poorly. The rectal temperature was 102° F. on admission to the hospital. Physical examination revealed a well-nourished, well-developed infant who did not appear acutely ill. The face was swollen, with bilateral edema of the eyelids and brawny edema of the jaws. Herpes was present on the upper lip and there were fissures at the corners of the mouth. Weight was 5010 Gm.

Admission laboratory studies: hb 74 per cent (10.2 Gm.); WBC 30,700, with a normal differential; sedimentation rate elevated to 60 mm. and 122 mm. in 15 and 45 minutes. Urinalysis, Kline and Kahn, 1:1000 tuberculin test, agglutination tests for typhoid, paratyphoid and brucellosis and serum proteins all normal. Spinal fluid clear.

Fever ranged from 100° F. to 102° F. and white count was 14,000 to 35,100 during the next 23 hospital days, in spite of 10,000 units of penicillin given IM every three hours. Subsequently, after intravenous pyelogram, the rectal temperature was below 100° F. Other treatment during this period included sulfadiazine, whole blood transfusions, streptomycin, 125 mg. every three hours for four days, a hypo-allergenic Mulsoy diet, oleum percomorph and ascorbic acid.

The infant continued to be irritable, preferred lying on the right side and assumed a position of opisthotonus. There was moderate nonpurulent nasal secretion. Edema of the eyelids was slight on the 18th hospital day.

A chest roentgenogram was negative on admission. On November 10 an excretory pyelogram was normal but revealed, as an incidental finding, 3 mm.† of hazy, irregular periosteal thickening along the ribs and clavicles. Other studies one week later showed similar 4 mm. involvement of the mid-long bones, mandible and scapulae. Comparison roentgenograms ten days later showed 4 mm. lamellated periosteal proliferation of the lower eight ribs, a 3 mm. density

adjacent the left iliac bone above the acetabulum, 5 mm. proliferation of the clavicles, 3 mm. along the mid-left humerus, 7 mm. along the mid-right tibia, 12 mm. proliferation at the lateral borders of the scapulae and some linear proliferation of the right radius, both femora and the left tibia. No changes were present in the metacarpals or metatarsals (figs. 1A and 2).

Blood calcium and vitamin A absorption curve were normal. Alkaline phosphatase was elevated to 54 King-Armstrong units and blood phosphorus was elevated

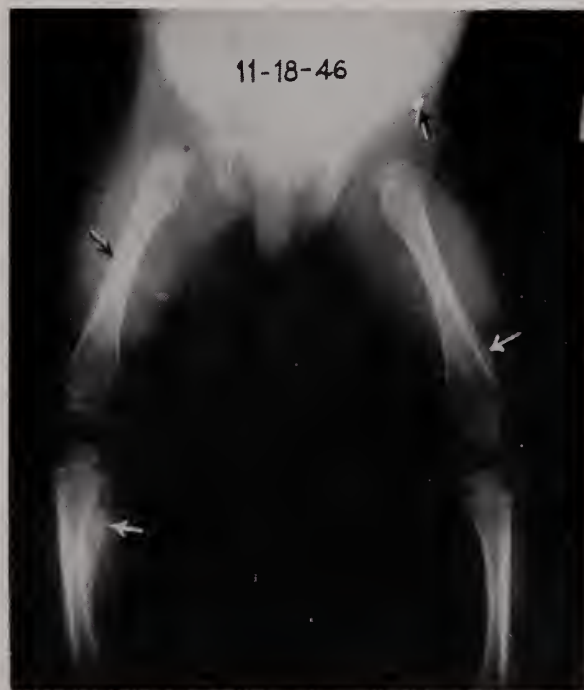


Fig. 2.—Case 1. White female, age 3 months, 5 weeks after onset. Note periosteal calcification of left ilium, femora, and right tibia, and calcification extending into soft tissues adjacent medial right tibia.

†The amount of the periosteal thickening, as measured directly on the roentgenogram, will be used to give an estimate of the degree of involvement.

to 7.4 mg.%. Spinal fluid, blood serology and blood culture were negative. Sedimentation rate was elevated to 24 mm. and 94 mm. in 15 and 45 minutes and WBC was 13,500. Serologic tests for lues on both parents were negative.

The infant weighed 5600 Gm. after 40 days hospitalization and was discharged improved.

Four months later, at seven and a half months of age, the infant appeared clinically normal. Roentgenograms showed increase in periosteal thickening and coarseness of trabeculation in both radii, both ulnae (fig. 1B), both femora and the right fibula. There was return to normal appearance of the mandible and the acetabulum, and decrease in thickening about the posterior ribs and clavicles. Marked thickening of the scapulae was still present with increased coarseness of trabeculation (fig. 3).

Comment: Initially, the roentgenographic appearance was considered compatible with congenital luetic periostitis. Repeated serologic tests on both the parents and the infant were negative. Scott Goodnight recognized the similarity to the syndrome reported by Smyth.²

Findings of interest were elevated alkaline phosphatase and blood phosphorus, extensive roentgenographic bone changes, temperature decline after intravenous pyelography, and no clinical response to penicillin, sulfadiazine or streptomycin. Involvement adjacent to the roof of the acetabulum has not been previously recorded in the literature.

CASE 2

Second case illustrates the feeding problem as the predominant presenting complaint before bone changes were apparent. In this instance, vomiting was initially considered as due to pyloric stenosis.

R. B., a one-month-old white male infant admitted to Doernbecher Memorial Hospital for Children on August 1, 1947, because of vomiting, irritability and weakness, for diagnosis and treatment of the feeding problem.

Family history revealed that the mother had asthma.

Past history: Bottle-fed, received supplemental vitamin D.

Present illness: Patient had been able to take small feedings but had vomited everything for the past 24 hours. Physical examination showed a dehydrated, warm infant with rectal temperature of 99.8° F. and weight of 2250 Gm. Visible peristalsis was not observed and no tumor was palpable in the region of the pylorus.

Laboratory: hb 80 per cent (11.0 Gm.), WBC 12,900, normal differential, sedimentation rate 0.5 mm. and 2 mm. in 15 and 45 minutes, negative Kahn and Kline tests, and granular casts in one of many urinalyses.

Roentgenographic studies of the stomach with barium showed normal pylorus and motility. There was no evidence of changes in ribs or long bones.

During 13 days of hospitalization the rectal temperature was not over 99.6° F. All feedings were retained. Therapy included oleum percomorph, ascorbic acid and whole blood transfusions of 80 cc. On discharge he weighed 2930 Gm.

He was re-admitted on September 6, three weeks after discharge, because of swelling of the left lower leg. The infant was afebrile and well hydrated. Physical findings were negative except for a 2 cm. tender, round mass which felt fixed to the upper posterior left tibia.

Roentgenograms of the long bones showed 1 mm. of linear periosteal density which was most marked in the femora and tibiae, but present also in the humeri, radii, mandible and ribs. The clavicles, metatarsals and metacarpals were normal.

Laboratory: hb 69 per cent (9.5 Gm.), blood calcium 10 mg.%, blood phosphate 6 mg.% and negative repeated serologic tests on both infant and parents.

The child did not appear ill and took feedings well; 155 cc. of whole blood was given in two transfusions because of the anemia. At discharge, after 12 days

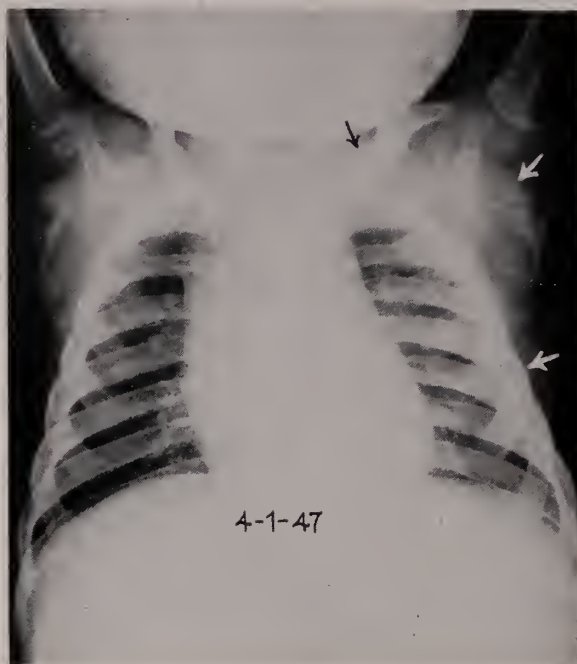


Fig. 3.—Case 1. White female, age 7 months, 5 months after onset. Note involvement of clavicles, tubular "onion-skin" ribs and marked changes in the scapulae.

hospitalization, the child weighed 3070 Gm. Three months later he appeared well.

Third admission was March 19, 1948, because of wheezing, fever and vomiting. These symptoms had been present since January, when he was treated with penicillin for pneumonia. Temperature was 103° F. and he vomited during several paroxysms of coughing. On examination he was alert, active and well-nourished. The ear drums were slightly reddened, wheezes and rales were heard in the chest and weight was 9520 Gm.

Chest roentgenograms showed prominent right hilar density and infiltration in the right apex. The ribs, scapulae, humeri, mandible and clavicles were normal.

The course became septic with spiking fever to 106° F. Death occurred on the fifth hospital day in spite of antibiotics and chemotherapy. Blood cultures were negative. Autopsy showed extensive bronchopneumonia and fatty metamorphosis of the liver. Bone studies were not done.

Comment: Minimal roentgenographic bone changes were first present at the age of two months and had disappeared at eight months. Death was due to intercurrent pulmonary infection.

CASE 3

This illustrates the typical moon-faced infant with mandibular swelling as the presenting complaint but without disturbance of feeding habits.

R. S., a three-month-old white female infant, was admitted to Doernbecher Memorial Hospital for Children on August 5, 1948, because of swelling on the right side of the face.

Past history: Full term, 7 pounds 4 ounces at birth, bottle fed, no feeding problem, had received cod liver oil and ascorbic acid and had had no previous illness.

Present illness: At the age of four weeks the parents noticed slight swelling of the right side of the baby's face. There had been rather marked variation in the size of the mass but it had never completely disappeared in the past two months. There was some redness when the swelling was marked but there had been no associated fever or upper respiratory infection. The child continued to eat well and had no obvious difficulty moving the jaw; however, there was definite tenderness.

Physical examination on admission revealed a hard, nonfluctuant, tender, fixed swelling over the ramus of the right mandible which extended into the sub-mandibular area. The parotid and sublingual ducts were normal. Rectal temperature was 98.6° F. and weight was 5150 Gm.

Admission laboratory studies: Negative urine, negative Kahn and Kline, WBC 10,000, normal differential, hb 76 per cent (10.5 Gm.), sedimentation rate was elevated to 17 mm. and 77 mm. in 15 and 45 minutes.

Roentgenograms showed 9 mm. of homogeneous periosteal density of the right mandible and 4 mm. of the left with adjacent soft tissue swelling, 1 mm. of linear periosteal density of the ribs, 2 mm. linear density of both ulnae and no involvement of clavicles or humeri or other long bones.

During the seven-day hospital stay the temperature rose to 101° F. for one day and returned to normal without specific therapy. He continued to eat well and did not appear ill. At discharge the clinical condition was unchanged and weight was 5160 Gm.

Five weeks later the swelling over the jaw was much decreased in size and the periosteal thickening was decreased in density.

Comment: This case shows typical involvement of the mandible as the predominant bone change.

CASE 4

Fourth case illustrates the course in a five-month-old infant considered to have a bone neoplasm from a roentgenogram of a single long bone. The multiple bone changes were more marked than in previous cases and periosteal changes in the ilium were similar to that in case 1.

J. H., a five-month-old white male, bottle-fed infant, was admitted to Doernbecher Memorial Hospital for Children on October 14, 1948, because of irritability, fever and poor appetite. Supplemental oleum percomorph, 10 drops, and ascorbic acid, 25 mg. daily, had been given since seven days of age.

Family history: The mother had had hives after eating strawberries.

Present illness: The baby was normal until about three months of age when he became fussy, developed intermittent fever from 101° F. to 102° F. rectally, fed poorly and vomited occasionally. These symptoms

continued and became intensified during the three weeks prior to admission with temperature to 103.6° F. He had an otitis media and received chemotherapy with local resolution but no general response. A runny nose and cough developed October 5. He was hospitalized elsewhere and was said to have received 40 shots of penicillin without improvement. Temperature had varied from 100° F. to 102.2° F. during the two days before admission.

On admission to the hospital physical examination revealed a well-nourished, irritable, moon-faced infant with swelling of the mandibular and zygomatic regions. There was slight redness of the ear drums and throat. Weight was 6110 Gm.

Laboratory studies: Acetone in the urine, hb 59 per cent (8.1 Gm.), WBC 27,200, normal differential sedimentation rate 1 mm. and 4 mm. in 15 and 45 minutes, femoral arterial blood culture of staph aureus was believed due to contamination, negative serology.

Roentgenograms showed 8 mm. of homogeneous dense thickening about the mandible (fig. 4A) and 1 mm. of linear density along the left posterior ribs. There were no changes in the long bones, clavicles, scapulae or ilia. A diagnosis of infantile cortical hyperostosis was made.

Therapy included penicillin 40,000 units every three hours, ascorbic acid, oleum percomorph, and 180 cc. whole blood in two transfusions.

He was discharged October 17 after four days of hospitalization, during which time his temperature had ranged from 99.6° F. to 101.6° F. Ascorbic acid, 200 mgm. daily, and oleum percomorph, 10 drops daily, were prescribed.

During the following months at home fever recurred and there was exacerbation of the previous complaints. Tender swelling of the left leg appeared. Roentgenogram of that extremity was made by a physician who told the mother that the baby had a bone cancer and recommended she bring him back to Doernbecher because the prognosis was hopeless.

Readmission examination November 22 showed a dehydrated, undernourished male who cried continuously and could not sit or crawl. There was prominence of the jaw, especially on the left. Thighs were flexed on the abdomen and the left thigh measured

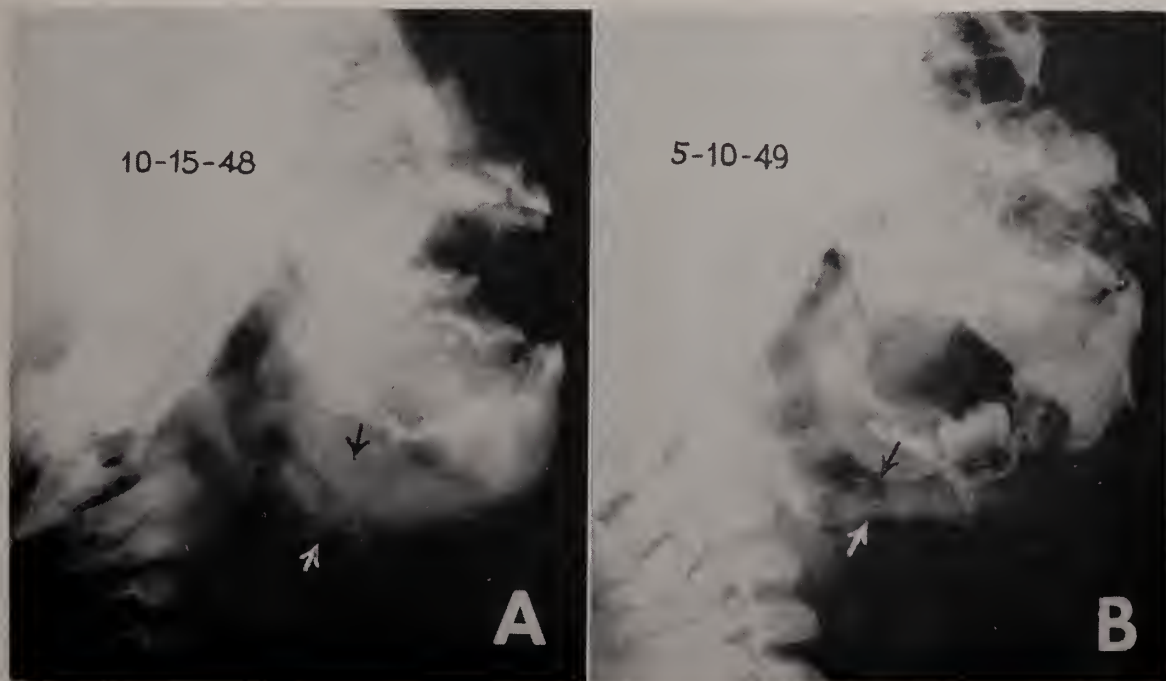


Fig. 4.—Case 4. White male. A: Age 5 months, 1 month after onset. Note increased thickness of the mandibular ramus and homogeneous ground-glass ap-

pearance. B: Age 12 months. Return to normal thickness with residual irregular inferior border.

1½ inches larger in circumference than the right. Palpable masses were deeply fixed over the mid-femora and left tibia. Temperature was 100.4° F. and weight 5900 Gm.

Laboratory: WBC 22,950, normal differential, hb 65 per cent (9.4 Gm.), sedimentation rate elevated to 12 mm. and 75 mm. in 15 and 45 minutes, acetone in the urine, acid phosphatase 5.3 King-Armstrong units and alkaline phosphatase increased to 21.4 King-Armstrong units.

Roentgenograms showed some decrease in the proliferation about the mandible, 3 mm. lamellated densities about the ribs (fig. 5), 2 mm. linear density about the right clavicle, no involvement of humeri or radii, 4 mm. lamellated density about the ulnae, 4 to 7 mm. of exuberant flocculent calcific density external to 3 to 4 mm. of linear subperiosteal calcification about the mid-femora (fig. 6A), 1 mm. linear density about the left tibia, 4 to 6 mm. of homogeneous density about the scapulae (fig. 5), and two rounded densities 4 and 6 mm. in size adjacent the left lateral lower ilium (fig. 6A). Metatarsals and metacarpals were normal.

Therapy included supportive measures plus 100 cc. whole blood transfusion. The mother was assured of a favorable prognosis.

The baby was discharged on the ninth hospital day without significant change in the general condition and weighed 5500 Gm.

Follow-up roentgenograms at seven and a half months of age showed decrease in thickness with increased coarseness and trabeculation of the exuberant density about the femora and tibiae (fig. 6B).

At the age of 12 months, the mandible and scapulae were normal, the changes in the long bones had markedly decreased and density adjacent the roof of the acetabulum had disappeared (figs. 4B and 6C).



Fig. 5.—Case 4. White male, age 6 months, 2 months after onset. Note periosteal thickening of clavicles, ribs and scapulae.

Sedimentation rate was normal and WBC was 16,200 with a normal differential. The child had begun to walk and weighed 8800 Gm. Roentgenograms, taken elsewhere at 18 months of age, showed definite bowing of the femora with 3 mm. of density along the lateral mid-femora but the bone width was restored to normal. There were no residual changes in the other long bones.

Comment: This case presents a most interesting picture of the progress of the widespread bone changes. The exuberant, flocculent, irregular calcific density outside the linear subperiosteal calcification (fig. 6A) suggests rupture of periosteal hemorrhage with calcification of hematoma thought characteristic of scurvy. Involvement of the ilium is similar to that shown in case 1. The blood alkaline phosphatase was elevated: A roentgenogram of a single bone was misinterpreted as bone sarcoma. There was no clinical response to antibiotics.

DISCUSSION

Clinical symptoms are of little differential value in infants since the general irritability and upset feeding habits are present in metabolic disease, infectious diseases, hypertrophic pyloric stenosis, and persistent feeding problems. Tender, soft tissue swelling over the mandibles, scapulae, clavicles or extremities requires roentgenographic examination of the underlying bone. Swelling over the jaws gives the typical moon-faced appearance which the clinician may recognize readily.

Laboratory findings are nonspecific. Delano and Butler feel that the leucocytosis and anemia suggest a nonviral infectious process and recommend massive doses of antibiotics for treatment. As in the other reported cases we found no clinical response to sulfadiazine, penicillin or streptomycin. Elevated serum alkaline phosphatase presumably occurs with bone production.

Allergic etiology has been considered. In three of the four cases presented here there was evidence of allergy in the family history. However, Mulsoy hypo-allergenic diet produced no clinical response. There was no increase in eosinophile count. None of the four cases was breast-fed. The temperature return to normal after the intravenous injection of Diodrast® in one case may have been coincidence but this observation should be checked by similar studies in future cases because the iodine compound may have been responsible for the clinical improvement.

Roentgenographic appearance is characteristic and gives the best basis for early diagnosis. Subperiosteal proliferation of the mandible, ribs, clavicles, long bones and scapulae is typical. Long bone changes are characteristically confined to midshaft and do not extend to the epiphyses. Early, the subperiosteal calcific density is homogeneous and approximates density of cortical bone. Later, calcification becomes coarse and trabeculated and decreases in density and extent.

Scurvy produces periosteal elevation and similar subperiosteal calcification which, however, extends

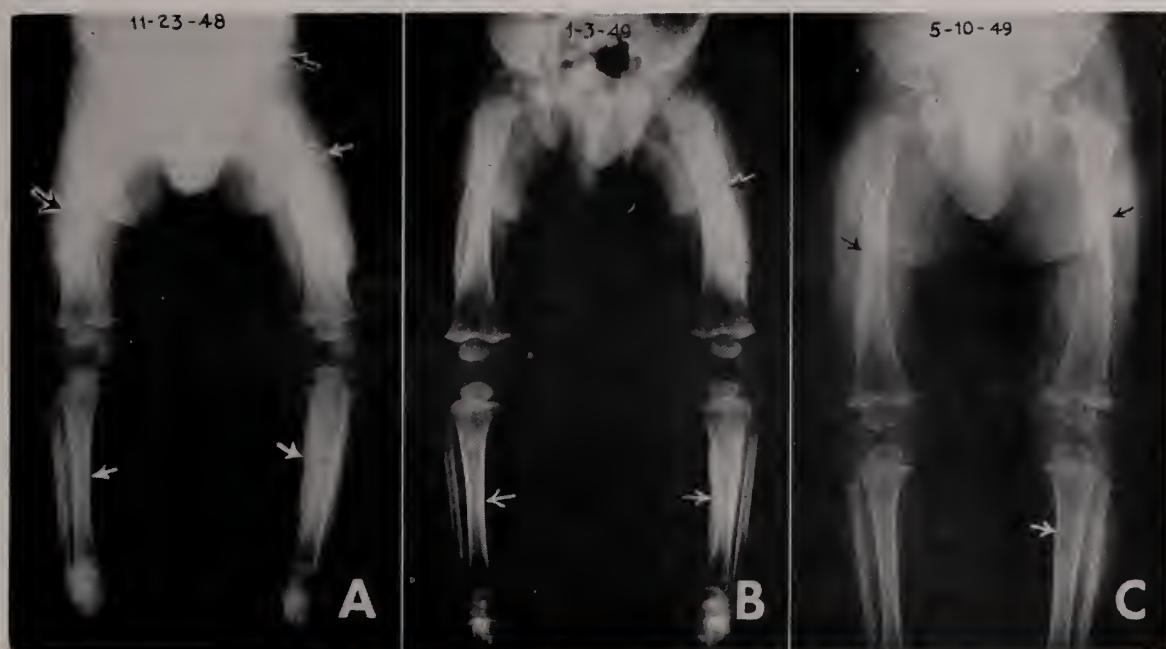


Fig. 6.—Case 4. White male. A: Age 6 months, 2 months after onset. Note extensive exuberant periosteal calcification of mid-femora and left tibia and calcific density adjacent the left ilium. B: Age 7½ months.

Lower extremities showing trabeculation and decrease in thickness of periosteal density. C: Age 12 months, 8½ months after onset, showing progressive return toward normal with slight bowing of the femora.

to the end of the metaphysis. There is associated the narrow accentuated pencil line zone of provisional calcification with fragmented borders at the metaphyses and decreased density of the secondary epiphyses. Vitamin C therapy produces immediate clinical improvement. Onset in the first few months of life or a history of adequate vitamin intake will rule out scurvy.

Disseminated bacterial osteomyelitis usually produces cortical destruction of the metaphyses, whereas infantile cortical hyperostosis shows no destructive tendency. Positive blood culture may be obtained and prompt clinical improvement results from adequate antibiotic therapy.

Syphilitic periostitis may appear similar to infantile cortical hyperostosis roentgenographically. In fact, the study of lueticlike bone changes in non-syphilitic infants^{16,17} led to discovery of the new entity. In bone syphilis there may be scattered areas of cortical destruction and even metaphyseal changes. Negative serology in infant and parents rules out lues.

Bone changes similar to infantile cortical hyperostosis occur in vitamin A poisoning. Caffey states that infantile cortical hyperostosis has its onset before six months of age and mandibular involvement is typical, while hypervitaminosis A occurs after one year of age and never involves the mandible. Changes in the metatarsals, long bones and

ribs have been observed in both conditions. Rothman and Leon noted only slight periosteal involvement with no lamellation in roentgenograms of two cases of hypervitaminosis A. Toomey and Morissette report clinical findings of hepatomegaly, sparse hair and weight loss without fever in Vitamin A poisoning.

History of concentrated fish liver oil intake above normal requirements is the clue to correct diagnosis. To obtain this history, however, it is necessary to question the parents specifically and sometimes only the grandmother can give a detailed account of the vitamins or number of drops being given. Blood vitamin A levels are increased in vitamin A poisoning and normal in infantile cortical hyperostoses. Removal of vitamin A from the diet produces rapid recovery.

Primary malignancy of bone is extremely rare in infants, is locally destructive and is a solitary lesion. In bone metastases from neuroblastoma, the roentgenogram usually shows destruction of cortex adjacent the epiphysis, a moth-eaten appearance not unlike disseminated osteomyelitis. Other cases may show elevation of the periosteum with production of reactive bone in perpendicular spicules. Brailsford¹⁸ reports an ossifying hematoma of the femur mistaken for sarcoma in a three-month-old infant. This, also, was probably really infantile cortical hyperostosis since changes were also noted in the tibiae. Our case 4 was diagnosed elsewhere as bone

16. Caffey, J.: Syphilis of Skeleton in Early Infancy: Non-Specificity of Many of the Roentgenographic Changes. *Am. J. Roentgenol.* 42:637-655, Nov., 1939.

17. Chiari, O.: Periosteal Reactions in Non-Syphilitic Children During First Three Months of Life. *Acta Paediat.* 22:436-440, 1938.

18. Brailsford, J. F.: Ossifying Hematomata and Other Simple Lesions Mistaken for Sarcomata. *Brit. J. Radiol.* 21:157-170, April, 1948 (Case 1, Fig. 10).

malignancy from a roentgenogram of a single extremity. Therefore, survey roentgenograms of long bones and thorax are indicated in any infant with periostitis or possible bone malignancy.

Van Seben⁹ noted residual forward curvature of the tibiae. We have no lateral roentgenograms of the extremities for comparison, but in our case 4 there is bowing of the femora which appears the same as the femora in Van Seben's fig. 9. Complete recovery is invariable with gradual restoration of bone to normal appearance.

Subperiosteal calcification in infantile cortical hyperostosis shows no associated cortical destruction and appears inert. This suggests that the

changes occur as a result of primary involvement of the periosteum which becomes elevated, perhaps due to edema, followed by deposition of new bone. Similarity of the roentgen appearance to scurvy and hypervitaminosis A suggests that etiology may be a nutritional or metabolic factor with an allergic response rather than infection. None of the therapeutic agents has had any effect on the clinical course, so a trial of antihistaminics may be considered. However, before using any new therapeutic agent, one should realize that the disease has had a benign course in all reported cases. Heroic or inherently dangerous therapeutic measures would not be justified.

Sunburn Prevention: A Vanishing Cream Effectively Opaque to Actinic Rays

WILLIAM J. HEMPHILL, M.D.
EUGENE, OREGON

WHILE sunburn is a miserable affliction, especially of the play time of the white collar worker, its prevention is of greater consequence to susceptible individuals in whom the sun's rays are carcinogenic.^{1,2}

The atmosphere absorbs ultraviolet radiation of wave length shorter than 2900 Å.³ Energy of wave lengths between 2900 Å and 3200 Å produces both sunburn and carcinogenesis.⁴ To be effective, a filter need afford adequate opacity only in this range. Such absorption has been shown to be a property of phenyl salicylate,⁵ para-aminobenzoic acid,⁶ and antipyrine.⁷

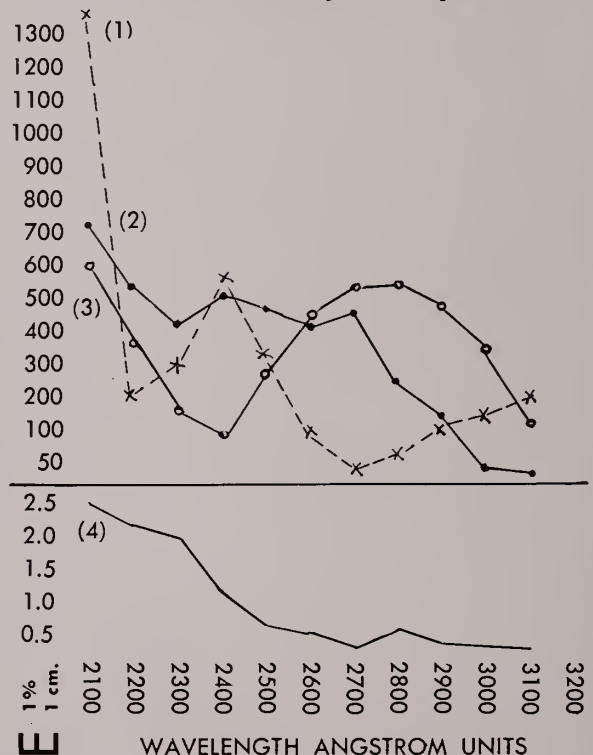
A vanishing cream was formulated, incorporating in Almay Emulsion Base,[®] 1 per cent phenyl salicylate, 5 per cent antipyrine and 5 per cent sodium para-aminobenzoate. Oil of roses was added to improve the vaguely distasteful odor:

R/ Phenyl salicylate	0.3
Antipyrine	1.5
Sodium para-aminobenzoate	1.5
Oil of roses	qs
Almay Emulsion Base [®]	qs ad 30.0

Sig: Apply thin, even layer prior to exposure to prevent sunburn.

Ultraviolet absorption characteristics were determined for each ingredient of the unguent through

Ultra Violet Absorption Spectrum



1. SODIUM PARA AMINO BENZOATE
2. ANTIPYRINE
3. PHENYL SALICYLATE
4. VANISHING CREAM

1. Hall, A. Fletcher: Relationships of Sunlight, Complexion and Heredity to Skin Carcinogenesis. Arch. Derm. & Syph., 61:589-610, April, 1950.

2. Lynch, Francis W.: Xeroderma Pigmentosum. Arch. Derm. & Syph., 29:858-873, June, 1933.

3. Blum, H. F.: Radiation: Non-Ionizing; in Medical Physics. Year Book Publishers, Chicago, edited by Otto Glasser, 753-766.

4. Blum, H. F.: Sunlight and Cancer of the Skin. J. Nat. Cancer Inst., 1:397-421, Dec., 1940.

5. Luckiesh, Matthew, Taylor, A. H. and Cole, H. N.: Protective Skin Coatings for the Prevention of Sunburn. J.A.M.A., 130:1-6, Jan. 5, 1946.

6. Rothman, S. and Rubin, J.: Sunburn and Para-aminobenzoic Acid. J. Invest. Derm., 5:445-457, Dec., 1942.

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the cooperation of the Department of Oncology of the University of Kansas Medical Center, utilizing the ultravioletmicrospectrophotometer (fig. 1). The vehicle possesses no effective filtration. Greatest filtration effectiveness of each active ingredient occurs in the shorter ultraviolet range, yet effective absorption is still present at 3100 Å.

The cream was tested against ultraviolet exposure from a Hanovia lamp which delivered one minimal erythema dose in 45 seconds at 30 inches. Skin of the abdomen was tested because of its relatively flat contour. Subjects used had not been exposed to the sun during the preceding six months. Duration of test exposures ranged from one to twenty minutes, or 1.25 to 27 minimal erythema doses. Complete protection of the tested sites was observed following exposure to 20 minimal erythema doses. After doses exceeding fifteen minutes, erythema was noted in test sites, but was less than in control areas.

It was tested in a technician who daily received so much erythema from operating a quartz lamp it was necessary to keep her out of the light room. She used the cream as a powder base on exposed parts and has been able to operate the quartz light completely free of any erythema for two months.

Exposure to natural sunlight was also tested. Samples of the cream were given fifteen subjects for use during ordinary week-ends of outdoor activity. All reported that reaction to sunshine was much less than expected. None was irritated by the preparation.

SUMMARY

A sun-screening vanishing cream which contains 1 per cent phenyl salicylate, 5 per cent sodium para-aminobenzoate, and 5 per cent antipyrine has been tested. Its ultraviolet absorption spectrum indicated maximum effectiveness from 2100 Å to 3100 Å. Clinical trials showed it to be effective in inhibiting sunburn.

Management of Respiratory Failure in Acute Poliomyelitis

RICHARD W. MAXWELL, M.D.† and

JOSEPH MUENSTER, M.D.,‡ ST. LOUIS, MO.

ROBERT F. L. POLLEY, M.D.,* SEATTLE, WASH.,

PROBABLY few aspects of poliomyelitis have received the widespread interest devoted recently to management of respiratory failure.¹⁻¹⁰ Some difference of opinion has occurred, particularly in regard to indications for tracheotomy and management of the tracheotomized patient.

During 1949 there were 168 cases of acute polio-

myelitis admitted to the Isolation Division of the St. Louis City Hospital. Our experience in management of respiratory failure led us to agree with reports emphasizing the dangers of anoxia. We also wish to point out the singular importance of an adequate airway.

States of anoxia and increased blood carbon dioxide tension should be carefully considered prior to any analysis of respiratory failure in poliomyelitis. This is because of the overlapping that occurs in the clinical and pathologic picture of poliomyelitis on one hand, and that of anoxia and increased carbon dioxide tension on the other.¹¹⁻¹⁷

Kubicek, Holt, et al¹⁴ pointed out the combination of destructive effects of poliomyelitis virus superimposed on the lethal effects of anoxia. Others have indicated that, of the large number of polio-

*Formerly of the Department of Pediatrics, St. Louis University School of Medicine, St. Louis, Missouri.

†Department of Medicine, Washington University School of Medicine, St. Louis, Missouri.

‡Resident in Medicine, St. Louis City Hospital, St. Louis, Missouri.

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3. Brown, Joe R. and Baker, A. B.: Poliomyelitis; Bulbar Poliomyelitis; Interpretation of Clinicopathological Findings. *J. Nerv. & Ment. Dis.* 109:54-78, Jan., 1949.

4. Wilson, James L., Outline of Essential Treatment in Bulbar Poliomyelitis. Poliomyelitis: Papers and Discussions Presented at the First International Poliomyelitis Conference, New York City, July 12-17, 1948. Pp. 245-249. J. B. Lippincott Company, Philadelphia, 1949.

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9. Baker, A. B.: Bulbar Poliomyelitis, Its Mechanism and Treatment. *Am. J. Med.*, 6:614-619, May, 1949.

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myelitis patients showing clinical symptomatology of cerebral involvement, only a small number actually show inflammatory changes within the cerebral hemispheres. Cerebral symptoms frequently disappear when measures are taken to provide adequate oxygenation of the patient.¹⁵

RESPIRATORS

Careful selection of all cases placed in respirators must be stressed. We found usefulness of respirators increased and hazards decreased by early performance of a tracheotomy.⁷

Prevention of pulmonary edema appears to depend on provision of an adequate airway and measures to combat stagnation of viscid secretions. Stimson states that in his experience 25 per cent of respirator cases developed atelectasis.¹⁹ We found frequent bedside roentgenograms very helpful in detecting onset of such pulmonary changes in respirator cases.

We were fortunate in having the Monaghan² type respirator available during the latter part of the 1949 epidemic. As with any respirator, first-hand experience and familiarity with its use are essential. We found the Monaghan respirator indispensable. It permits tracheotomy after the patient is placed in it. This situation is quite different from that encountered with the conventional respirator. Difficulty was noted in using the Monaghan on heavy-breasted females. Apparently this was due to the fact that the breasts and subcutaneous tissue occupied so much of the dead space in the chest plate. Thus adequate negative pressures could not always be obtained. With children, our results with the Monaghan respirator were excellent. Its use in weaning both adults and children from the conventional respirator was valuable.

PREVENTION OF REGURGITATION AND ASPIRATION

A number of our acute cases presented considerable nausea and vomiting. Several adults regurgitated quantities suggestive of a definite ileus. Gastric atony and ileus with poliomyelitis have been pointed out.^{9,20} We appreciated the hazards of vomiting, particularly in patients with impaired swallowing, coughing and breathing function. Even with a tracheotomy, a regurgitating patient in a respirator presents a critical situation.

We employed Wangenstein suction on a trial basis. Despite the lack of evident ileus it occasionally removed upwards of four litres of gastric content in 48 hours. Therefore, we incorporated early Wangenstein suction in the handling of acute cases. Having had bitter experience with vomiting

and aspiration, we came to acknowledge the symptom of persistent nausea as an indication for trial gastric suction. If an insignificant amount was removed within a short period the suction was discontinued. Supporting gastric suction also was the observation that excursions of the respirator occasionally elicited regurgitation in patients previously free.

TRACHEOTOMY

Tracheotomy appears to be the most effective means of providing an adequate airway. This procedure provides an airway which bypasses the upper respiratory tract, with its many threats to airway patency.

The performance of tracheotomy before the patient is in acute distress is simple as compared to the same procedure on a patient anoxic and struggling for breath, or confined to a respirator. The difference is so marked that the two procedures hardly belong in the same surgical category. Our observations during the first part of the 1949 epidemic confirmed evidence in the literature favoring early tracheotomy in patients with respiratory failure. Thus we were encouraged to give early tracheotomy a free trial during the latter part of the summer of 1949.

Those who are reluctant to promote wide use of tracheotomies have been so, for the most part, without any specific contraindications. They object because they have been satisfied with results of handling most respirator cases conservatively.^{4,19,21} Of significance may be the observation that those opposing early tracheotomies are groups not having had experience with elective tracheotomies on a large scale. We have failed to find unfavorable reports from workers who have given tracheotomy a fair trial. It might appear, therefore, that personal experience with free use of tracheotomy teaches a lesson in itself.

Some of our cases receiving tracheotomies on admission rapidly went into respiratory failure and were placed in a respirator. Early tracheotomies in these instances provided a better prognostic outlook. The distasteful task of performing tracheotomy on a patient in a respirator had been avoided. No matter what degree of involvement ensued, we had a patient with an airway whose patency could be maintained. This handling was far superior to the most judicious use of suction in the nose and throat.

Despite our free use of tracheotomies we were unable to conclude in retrospect that any would have been better off without tracheotomy. Admittedly, some might have been successfully cared for by conservative measure had we waited. However, tracheotomy did not in any way make the

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21. Paul J. R.: Poliomyelitis; Early Diagnosis and Early Management of Acute Cases. *Ann. Int. Med.*, 30:1126-1133, June, 1949.

milder cases more difficult to handle. They were more easily and safely cared for. When the tracheotomies were done there was no way of predicting which patients would progress to upper cord or bulbar involvement. Thus tracheotomies were done on some not needing the operation. Prophylactic value in the others was high. Some would have developed anoxia had tracheotomy been delayed until frank clinical respiratory distress appeared.

Adult tracheotomy patients did not complain of undue discomfort. In several instances they objected when the tube was removed. Children with tracheotomies were never noticeably uncomfortable on this account. No complications occurred which were referable to the tracheotomies.

After tracheotomy had been freely utilized for the first time at the Isolation Division of the St. Louis City Hospital, four general observations could be made:

1. Tracheotomies are not as traumatic, painful or dangerous as frequently described.
2. Fewer fulminating cases prove to be terminal when anoxia is energetically combated.
3. Lung findings of tracheotomized patients differ significantly from those of a similar group of patients in which tracheotomy is not the rule.
4. Inexperienced nursing care can more safely handle critical respiratory failure cases if these patients have tracheotomies.

INDICATIONS FOR TRACHEOTOMY

Indications for tracheotomy listed by Galloway,¹ Baker² and West³ for the most part coincide with those evolved by our experiences. Procrastination, as mentioned by Galloway, is bound to occur. His group posted indications for tracheotomy on the wall as a constant reminder. Other workers condemned the tendency to delay tracheotomy.^{7,10,14,22} Through continued self-criticism and evaluation of our tracheotomy policy, our conclusions suggest another approach to the problem. One could consider the circumstances when a tracheotomy may be conscientiously decided against or postponed:

1. Patients of the non-paralytic or low-spinal variety;
2. Progressive cases still far short of marked respiratory and bulbar involvement and far short of evident anoxia;
3. High-spinal cases, who seem relatively certain to escape the need of artificial respiration.

Whether or not the patient becomes a pure bulbar and is handled out of a respirator, a bulbo-spinal and is placed in a respirator, or develops an encephalitic picture, the tracheotomy provides a short, uncomplicated route for inspiration and expiration.

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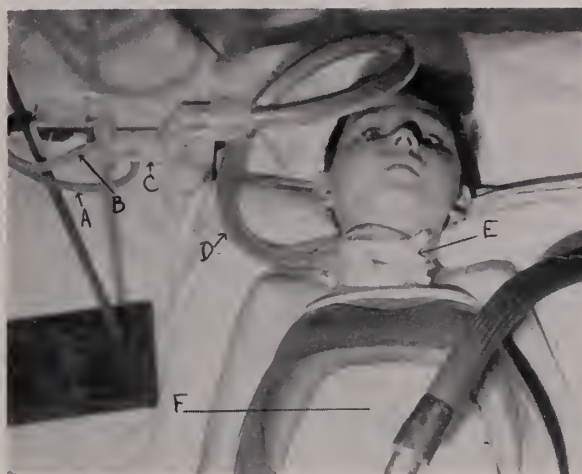


FIG. 1

- (A) Tube delivering water to nebulizer.
 (B) Tube delivering oxygen to nebulizer.
 (C) Tabor nebulizer.*
 (D) Adapter and plastic hose delivering oxygen and aerosol ("cold steam").
 (E) "Tracheotomy Mask" on anterior surface of neck enclosing tracheotomy orifice.
 (F) Monaghan respirator.

*Nebulizer and "tracheotomy mask" manufactured by Carl Tabor, 3401 Gravois Ave., St. Louis, Mo.

OXYGEN ADMINISTRATION

Administration of oxygen to the poliomyelitis patient with respiratory failure entails considerable mechanical difficulty. Factors contributing to an inadequate airway do not improve effectiveness of oxygen administration and utilization. Hazards of dry, thick mucus in the patient with faulty pulmonary function are apparent.^{23,26} Oxygen is known to have a considerable anti-expectorant action.²⁵ This is particularly noticeable when administered per tracheotomy tube. Hence, adequate humidification of air and oxygen inspired via tracheotomy tube is of the greatest importance.

We have had very encouraging experience using a nebulizer as a continuous source of an oxygen-aerosol mixture.²⁷ This oxygen-aerosol (cold steam) mixture is delivered through a plastic hose, to a plastic tracheotomy mask which lies on the anterior aspect of the neck, enclosing the tracheotomy orifice. Exhaust holes in the mask permit escape of carbon dioxide. The patient in this manner breathes an atmosphere of high oxygen concentration and high humidity. (fig. 1)

Having taken steps to provide an adequate airway and keep respiratory tract secretions thin, it is

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27. Black, E. W. and Poncher, H. G.: Inhalation Therapy in Pediatrics. *Am. J. Dis. Child*, 76:169-175, Aug., 1948.

important to follow through with postural drainage and frequent removal of mucus from the airway by suction.

STATISTICAL DATA OBTAINED DURING THE 1949
EPIDEMIC IN ST. LOUIS

Incidence of Pulmonary Edema. Voluminous data, clinical and experimental, have been presented regarding the pathogenesis of pulmonary edema.^{18,28,29,30} A comprehensive discussion of all the factors involved is not within the scope of this paper. However, of interest is the incidence of pulmonary edema found in victims of acute poliomyelitis dying in a respirator. Table I shows the

TABLE I*
MAJOR LUNG PATHOLOGY AT AUTOPSY

	Pulmonary Edema	Atelectasis, Pneumonia Congestion, and Other	Percentage with Pulmonary Edema
--	--------------------	---	--

20 Respirator cases No tracheotomy	16	4	80
10 Respirator cases With tracheotomy	0	10	0

*Data obtained through the courtesy of the staffs of several hospitals in the St. Louis area.

relative incidence of pulmonary edema as found at the autopsy of patients handled in respirators, with and without tracheotomies. It is presumed that patients having tracheotomies represent a group whose airway was consistently more patent than those without tracheotomy.

The inspiratory excursion of a respirator, working against an occluded airway, increases intrathoracic negative pressure. This increased negative pressure could, therefore, exaggerate the pressure gradient favoring transudation of edema fluid from the lung capillary bed into the alveoli.¹⁸

The high incidence of pulmonary edema in the group without tracheotomy, as compared to the low incidence in tracheotomized patients, indicates the importance of a patent airway in prevention of pulmonary edema.

Tables II and III show the number and type of cases seen and illustrate somewhat the degrees of success attained by various methods of handling bulbar and bulbo-spinal cases at the St. Louis City Hospital in 1949. As mentioned earlier, the plan of therapy changed considerably during the 1949 epidemic. The cases handled in the iron lung without tracheotomy, and the patient that succumbed under conservative management, were admitted to the hospital early in the epidemic. Those handled with a tracheotomy alone, or with a tracheotomy and

Monaghan respirator were seen later on in the epidemic.

CONCLUSIONS

The following procedures represent steps to be considered in following an energetic prophylactic program:

1. Immediate oxygen per tent.
2. Trendelenburg position.
3. Suction of the upper respiratory tract.
4. Wagensteen gastric suction.
5. Correction of dehydration and acidosis.
6. Early tracheotomy.
7. Delivery of humidified oxygen per tracheotomy orifice.
8. Respirator.

We have outlined circumstances when a tracheotomy may be conscientiously decided against or postponed rather than cite a long list of indications.

Combining cold steam and oxygen therapy is a very important step in care of the tracheotomized patient.

Effectiveness of an energetic therapeutic and prophylactic program depends on careful attention to minute details until the patient's course is stabilized. Close teamwork between medical, pediatric and E.N.T. staffs is most essential.

Conservative programs have not produced, in our experience, the same favorable therapeutic response that we found could be achieved by this more active plan of therapy.

TABLE II
Cases of Acute Poliomyelitis—

Abortive (non-paralytic) type	56
Spinal (paralytic) type	77
Bulbo-spinal type	29
Bulbar only	6

Total cases of acute poliomyelitis	168
Total number of cases with bulbar signs	35
Number of deaths	13
Over-all mortality rate on 168 cases	7.73%
Mortality rate on 35 cases with bulbar signs	37.10%
Number of tracheotomies performed	22

TABLE III
ANALYSIS OF BULBAR AND BULBO-SPINAL CASES
ACCORDING TO MODE OF THERAPY

	Cases	Survivals	Deaths
1. Iron Lung	3	1*	2
2. Iron Lung with Tracheotomy	9	2†	7
3. Iron Lung, later weaned to Monaghan	2	2	
4. Monaghan only	1		1‡
5. Monaghan with Tracheotomy	6§	4	2
6. Tracheotomy only	6	6	
7. Handled with conservative measures	10	9	1
Totals	35	22	13

*Remained in iron lung just 24 hours.

†One surviving patient in iron lung just five days.

‡Eight-week-old infant with fulminating bulbo spinal poliomyelitis.

§Includes the two patients carried in iron lung at first and transferred to Monaghan respirator.

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Primary Carcinoma of Fallopian Tube

R. D. FORBES, M.D. AND B. L. FINLAYSON, M.D.

SEATTLE, WASHINGTON

PRIMARY carcinoma of the Fallopian tube is one of the rarest yet one of the most malignant tumors of the human body. Symptoms are often so minimal that the patient may neglect to secure aid during the time curative treatment is possible.

Only 16 cases in 10,000 primary malignancies of the female generative organs were found at the Mayo Clinic during the years 1910 to 1943,¹ a percentage of only 0.16. Stuebler and Brandess² cite an incidence of 0.45 per cent in their collected series. Only one case in 19,439 gynecological admissions was reported from the University of Pennsylvania Hospital.³ Many surgeons never see one in a lifetime of active service. Willis⁴ lists a series of 625 cases of carcinoma of the tubes without a single instance of primary involvement.

The high degree of malignancy is indicated by the statement that the most important element in consideration of carcinoma of the fallopian tube lies not in its rarity but in the fact that it represents the most malignant form, not only in genital carcinoma, but of carcinoma anywhere in the body.⁵

To Reynaud, in 1847, is attributed the first gross description⁷ and Rokitsansky is generally accredited with the first microscopic report in 1861.^{1,23} However, in 1886 Orthman reported but discarded them all as being secondary growths.⁸ To him therefore may be attributed the first authentic report of a primary adenocarcinoma of the fallopian tubes.

The difficulties in differentiating primary from secondary carcinoma of a tube, when the fundus or ovaries are involved, is such that it is impossible to state with accuracy the number of primary growths so far reported. By January 1947 a total of 450 cases were collected from the literature,⁹ but in 1947 Erik Block, reporting from Sweden was able to gather only 379 proven cases.¹⁰ R. M. Hill reports

a recently recorded case, February 1950.²⁴ Possible further error is present inasmuch as microscopic sections reported as carcinoma have later been recognized as tuberculosis.^{11,21} The similarity of these two lesions, both grossly and microscopically, is repeatedly mentioned. However, there are undoubtedly a number of cases, recognized and unrecognized, that have not been reported.

The age incidence has varied from 18 to 80 years. In one group 66 per cent were found to be between 45 and 55 years of age.¹² This is in contrast to the majority of cases of carcinoma of the fundus which occur between 55 and 65—10 years later than the average of carcinoma of the tubes.

It should be emphasized that early symptoms are slight or even absent. We have been able to find only two authors, Dannreuther and Hoffman who have reported a correct diagnosis made preoperatively.¹³ However, one or another of the three cardinal symptoms of this condition is usually present. Bleeding is the earliest and most important single symptom. Pain appears early in the disease, which is in contrast to cancer of the fundus or ovary. The irregular bleeding from this tumor, in pre-menapausal patients, is often mistakenly thought to be due to an approaching climacteric.²² Varying degrees of lower abdominal distress are frequent in women approaching the menopausal stage, causing this symptom to be easily missed. The distress in some cases is relieved by a sudden vaginal discharge of sero-sanguinous or bloody material extruded from the tube. This intermittent release of serous or bloody fluid has been termed "Hydrops Tubae Profluens."^{7,21}

With the triad of symptoms present, namely: irregular bleeding with an intermittent sudden release of fluid, lower abdominal distress, and a palpable adnexal mass, one should always bear in mind the possibility of carcinoma of the tube. In fact Martzloff¹⁴ considers the serosanguinous discharge alone to be pathognomonic of this condition, providing the uterus and vagina are normal.

Therefore, the presence of a normal cervix and vagina with recurring intermenstrual bleeding fol-

1. Lofgren, K. A. and Dockerty, M. B.: Primary Carcinoma of Fallopian Tubes. *Surg. Gynec. & Obst.*, 82: 199-206, Feb., 1946.

2. Stubler, E., Brandess, T.—as quoted by Anspach, B. M. 3.

3. Anspach, B. M.: Early Diagnosis of Adnexal Cancer. *Am. J. Obst. & Gynec.*, 20:571-581, Oct., 1930.

4. Willis, R. A.: *Spread of Tumors in the Human Body*. J. and A. Churchill, p. 306, London, 1934.

5. Parsons, L.: Carcinoma of Fallopian Tube. *New England J. Med.*, 221:367-373, Sept. 7, 1939.

6. Mitchell, R. M. and Mohler, R. W.: Primary Carcinoma of Fallopian Tube. *Am. J. Obs. & Gyn.*, 50:283-292, Sept., 1945.

7. Holland, W. W.: Primary Carcinoma of Fallopian Tubes. *Surg., Gynec. & Obst.*, 51:683-691, Nov., 1930.

8. Besold, Edw.: *Die Neubildungen der Eileiter*. In Martin, A.: *Die Krankheiten der Eileiter*, Leipzig, 1895, as quoted by Mitchell & Mohler.⁶

9. Curran, J. F. and Kilroy, E. A.: Primary Carcinoma of Fallopian Tube and Breast. *New England J. Med.*, 236:64-65, Jan. 9, 1947.

10. Block, E.: Primary Carcinoma of Fallopian Tube. *Acta Radiol.*, 28:49-68, 1947.

11. Fullerton, W. D.: Primary Carcinoma of the Fallopian Tubes. *Am. J. Surg.*, 48:467-472, May, 1940.

12. Wechsler, H. F.: Primary Carcinoma of Fallopian Tubes. *Arch. Path. & Lab. Med.*, 2:161-205, Aug., 1926.

13. Dannreuther, W. T.: Primary Carcinoma of Fallopian Tube, with Report of Case. *Am. J. Obst. & Gynec.*, 30:724-727, Nov., 1935.

14. Martzloff, K. H.: Primary Cancer of Fallopian Tube: Consideration of Its Incidence, Clinical Diagnosis, and Treatment, with Report of Case Diagnosed before Operation. *Am. J. Obst. & Gynec.*, 40:804-821, Nov., 1940.

lowing a negative D. and C., should always arouse suspicion even though no mass is palpable and no pain or distress is present. This is especially true if the D. and C. reveals an atrophic endometrium, ruling out a possible granulosa cell tumor of the ovary.¹⁵

Most frequent site of involvement is the distal third of the tube. A few originate in the isthmus. Those arising from the isthmus are thought to spread more rapidly and are reportedly even more malignant than those in the distal portion of the tube. This would indicate that the open fimbriated end of the tube plays little if any role in the spread of this malignancy. Actually the fimbriated end may be closed early in the process by invading cancer cells. Only relatively late does the tumor grossly break through the serosa and directly invade adjacent organs, although early and extensive adhesions are frequent.

Degree of accuracy and difficulties of interpretation of Papanicolaou smears are still a matter of discussion, but material for examination is so readily obtained that the procedure should be encouraged as a further aid in the diagnosis.

Incidence of bilateral involvement averages around 24 per cent. One series of 93 collected cases reached 45 per cent. Efforts have been made to explain this through the possibility of malignant cells traversing the path followed by transmigration of the ovum. This method is difficult to understand, especially inasmuch as involvement of the endometrium, other than by direct continuity is rare.^{11,16}

The reason for its reported extreme degree of malignancy and early metastasis is equally difficult to understand. The frequency with which these relatively small, grossly limited tumors have been reported to have associated hepatic or regional lymphatic involvement is striking. The dictum of Doran¹ that "The growth follows the line of least resistance, except that the ostium closes early," may be true. However, it does not explain how or why the metastatic involvement is so much earlier and more rapidly fatal than with microscopically similar tumors arising from the ovary, fundus or broad ligament and utilizing the same routes of dissemination.

There are three main lymphatic pathways.⁴ The major group joins with the ovarian plexus which in turn feeds into the iliac, lumbar and periaortic nodes. A lesser group traverses the round ligament to end in the inguinal nodes. A still smaller group travels distally along the course of the utero-sacral ligaments. Henderson reports a recurrence in the

cervix two years after a subtotal hysterectomy with bilateral salpingo-oophorectomy.

The frequency of hepatic involvement, even though the local growth is minimal in size, would indicate the probability of spread through continuity of closely applied omentum or bowel which enables the tumor cells to gain entrance to the portal system. However, the liver may also be invaded transperitoneally by cells set free in the peritoneal cavity.

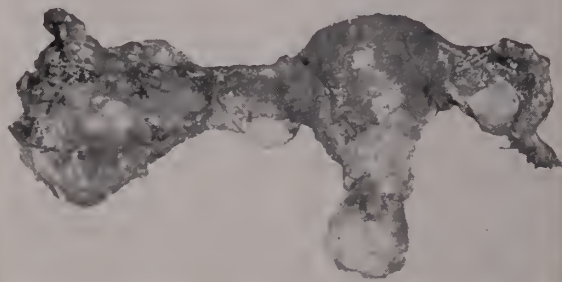


Fig. 1. Uterus tubes and ovaries (posterior view) showing the hemorrhagic serosa with gross invasion. The tumor mass is 2 cm. distant from the ovary. The end of the tube is completely sealed.

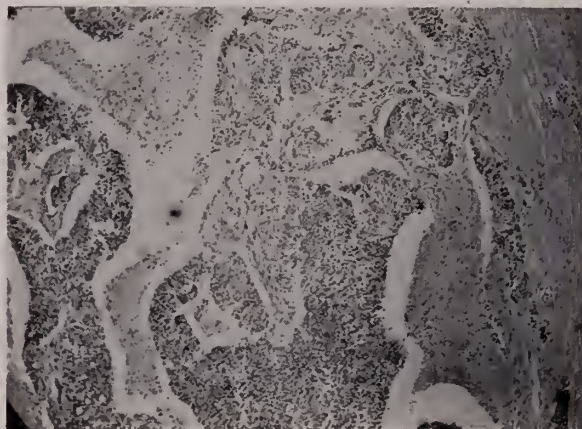


Fig. 2. Photomicrograph (approximately 50x) of a section revealing the papillary tendency of the growth and invasion of the muscle.

The gross appearance of these tumors often resembles pyosalpinx, endometriosis or tuberculosis. The lesion is thought to originate as a papillomatous growth from the mucosa, progressing from papillary to alveolar in type.^{18,19} The latter, represents the more malignant stage.²⁰ Growth of cells early fills the narrow lumen and distends the muscular coat but gross invasion through the tube wall is relatively late. This is in spite of the fact that the fallopian

17. Ewing, James.: *Neoplastic Diseases*. W. B. Saunders Co., Philadelphia., ed 4, 1940.

18. Phaneuf, L. E.: Primary Carcinoma of Fallopian Tube with Report of Case. *Am. J. Surg.*, 39:620-626, March, 1938.

19. Broders, A. C.: *Grading of Carcinoma*. Minn. Med., 8:726-730, Dec., 1925.

20. Papanicolaou, G. N. and Traut, H. F.: *Diag. Uterine Ca by Vag. Smear*. London, Oxford, 1943.

15. Novak, Emil.: *Gyn. & Bost. Path.* W. B. Saunders Co., Philadelphia, ed. 2.

16. Bower, J. O. and Clark, J. H.: Primary Bilateral Carcinoma of Fallopian Tubes; Recognition of Early Metastasis Essential to Successful Treatment. *Arch. Surg.*, 11:586-597, Oct., 1925.

tube has no muscularis mucosae and the mucous membrane is in direct contact with the muscle.

Treatment of carcinoma of the fallopian tube has tended toward increasingly radical surgery. The various modes of transmission would indicate importance of complete dissection of the pelvic and at times the inguinal lymph nodes.¹⁶ However, the end results are still disappointing.

The Radiumhemmet in Stockholm, Sweden,¹⁰ reporting on 16 cases, has recently attempted to improve the generally poor results by doing only a bilateral salpingo-oophorectomy, leaving the uterus in place, which is then utilized postoperatively for insertion of radium. This brings radium into closer contact with the areas of possible recurrence than when it is placed in the vagina. They report encouraging results and feel that in their hands this has given better results than previous procedures. If further experience corroborates this indicated improvement, their procedure may become the one of choice. However, in their cases, the essential factor in prognosis, as could be expected, was the extent of the growth at the time of treatment. All those having gross extension beyond the tube at the time of surgery died within three months to four years.

To offer a fair chance of recovery by surgical means alone necessitates such radical pelvic dissection that not only is the primary surgical mortality high but the post operative morbidity is at times disturbing.

CASE REPORT

This white female, age 51, para 2, weight 160 lbs., was first seen June 28, 1947, because of irregular brownish vaginal discharge and lower abdominal distress. Following four months of irregular menses she had had an amenorrhea for six months after which a brownish discharge began. It was present irregularly thereafter.

Physical examination revealed a normal vagina, hard cervix and a uterus normal in size and freely movable. A small, indistinct mass of questionable origin was present in the region of the left ovary.

A tentative diagnosis of probable ovarian cyst was made and a D. and C. done July 15, 1947. Curettings consisted of a few small, friable, greyish red fragments which, on microscopic section, revealed a non-secretory endometrium with compact stroma. There was no evidence of malignancy and there were no isolated malignant cells. (A later review of the slides still failed to reveal the presence of any suspicious cells.) The patient was placed on small doses of oral estrogen therapy and asked to return in one month. She was next seen October 13, 1947, having a continuation of irregular brownish vaginal discharge. The small mass in the left adnexal region was again noted and a diagnosis of probable carcinoma of the left tube was made.

A laparotomy was accomplished November 3, 1947, at which time the uterus, both ovaries and right tube appeared edematous but otherwise normal. The left tube was enlarged in its distal portion by a soft, dark red mass to which the sigmoid and a portion of the omentum were adherent. General abdominal exploration failed to reveal any palpable sacral, lumbar or periaortic nodes. Several glands, varying in size up to 1 cm., were present in the mesentery and shotted of

the pelvic peritoneum was present. Two umbilicated nodules, 2 and 3 cm. in diameter, were also palpable on the superior surface of the liver, one in each lateral lobe.

In spite of the obvious incurability, removal of the primary growth seemed advisable. Therefore, a total hysterectomy with bilateral salpingo-oophorectomy was done.

Postoperative convalescence was uneventful and the patient was discharged on her tenth postoperative day.

The gross specimen revealed the tube and the mass to be poorly defined and continuous. The tumor was completely distinct from the adjacent ovary, being at least 2 cm. distant at the closest point. The uterus and opposite tube and ovary were likewise not involved.

The microscopic appearance was typical: "Sections of the tumor present a varied picture. In most areas the tumor cells are extremely large, with large, irregular, variable, vesicular nuclei. Numbers of mitotic figures are apparent. There is a tendency toward sclerosis of the intrinsic stroma of the tumor. In other areas the growth is distinctly papillary with large zones of necrosis and, in a few small locations, the tumor is reminiscent of a papillary adenocarcinoma of the ovary. However, the other patterns are entirely consistent with primary malignancy of the fallopian tube. The section of uterus presents well-defined, compact musculature and endometrium which is showing some evidence of estrogen effect appearing consistent with late proliferative phase."

Postoperative convalescence was uneventful and she returned to her family physician for follow-up and subsequent hospitalizations. During the next six months her condition remained good. She then began having loss of appetite, occasional blood-tinged diarrhea and a rapidly enlarging abdomen with ascites. Repeated paracentesis and removal of amounts up to 3,000 cc. gave temporary relief. The clear amber fluid removed contained carcinoma cells. Examination on her last hospital admission revealed a poorly defined non-tender, supra-umbilical mass within the abdomen and a similar fixed mass in the pelvis. The patient continued to lose weight and strength until her death December 23, 1948, approximately 14 months post-operatively. At no time in her several hospitalizations was any chest symptomatology present or abnormality noted.

Postmortem examination revealed extensive papillary adenocarcinoma of the bladder, rectum, sigmoid, peripelvic tissues and vaginal vault; with metastasis to pelvic, periaortic, mesenteric and mediastinal nodes, also to the liver, spleen, adrenals and lung. The mass in the epigastrium was an enlarged nodular liver. Multiple gross metastatic tumor nodules were present in the left lung without hydrothorax. It was of more than passing interest to also find a right hydrothorax, 700 cc. with pneumonia, which, on microscopic examination, proved to be tuberculosis pneumonia and which was adjudged her immediate cause of death.

SUMMARY

Primary carcinoma of the fallopian tubes is a rare and highly malignant tumor.

Consideration of the possibility of carcinoma of this organ is the first step in diagnosis, which may be further aided by keeping in mind a triad of

21. Barrows, D. N.: Primary Carcinoma of Fallopian Tube, with Report of Three Cases. *Am. J. Obst. & Gynec.*, 13:710-719, June, 1927.

22. Judd, D. B. and Masson, J. C.: Primary Carcinoma of Fallopian Tubes. *Proc. Staff Meet. Mayo Clinic.*, 21: 183-184, May 1, 1946.

23. Bancroft-Livingston, G.: Primary Carcinoma of the Fallopian Tube. *J. Obs. & Gyn. of British Emp.*, 453-460, Oct., 1946.

24. Hill, R.: Primary Carcinoma of the Fallopian Tube; Review and Case Report. *Western Journal of Surg.*, 66:680, Feb., 1950.

symptoms often present, viz: irregular bleeding with intermittent sudden release of fluid, lower abdominal distress, and a palpable adnexal mass.

The results of treatment depend primarily on

the degree of extension present at the time of surgery. Other considerations are the extent of the resection accomplished, and in selected cases, the use of adequate radiation therapy.

Banthine in Herpes Zoster

HUGH S. BROWN, M.D., RICHARD D. REEKIE, M.D., and WILLIAM J. SINCLAIR, M.D.

SPOKANE, WASH.

We have observed immediate relief of symptoms by Banthine in two patients who had acute symptoms of Herpes Zoster.

Case 1. A young woman, aged 24, noted the onset of small herpetiform lesions of linear distribution below the right scapula, in the right axillary area, and under the right breast. These were exquisitely painful to touch. In the area of distribution of the sixth dorsal nerve root there was noted a band of hyperesthesia. Clinical diagnosis was Herpes Zoster.

She was started on 100 mg. of Banthine every six hours. The next day she stated that there had been almost complete relief within 30 minutes after the first dose. Hyperesthetic areas were barely sensitive to touch. The dull constant pain returned five and one-half hours after each dose and was abolished by the succeeding dose. The next day the lesions appeared to be drying. There was no pain or hyperesthesia. Dosage was cut to 50 mg. every four hours because of dryness of the mouth. Two days later she felt completely well. Skin lesions were definitely dried and some crusting was present. Medication was stopped. At the end of ten days the crusted areas had almost disappeared. Two months later she stated that she had had no further trouble.

Case 2. A male, aged 54, developed severe right chest pain and back pain two days before herpetiform lesions erupted at the level of the third rib at the costo-chondral junction. There was hyperesthesia of the whole third nerve root segment. He was given dilaudid, empirin and codeine, aspirin, demerol, pantopon and finally aureomycin for four days without relief. He was given 100 mg. of Banthine in the office and kept under observation. After thirty minutes he stated that pain was about gone. Hyperesthesia had decreased also. He was placed on 100 mg. every six hours day and night. Next day the areas of hyperesthesia were absent, herpetic lesions were drying and they were not tender to touch. At the end of 48 hours the herpetiform lesions were dry. They were no longer tender and there was no hyperesthesia. Medication was stopped after 72 hours. He had no further pain or

discomfort. After seven days he stated that he had had complete relief after the first few doses.

Case 3. A male, aged 73, was seen in the office and the complaint was of an eruption around the right lower chest which was very painful. It had been present for four days. On examination, the characteristic herpetic lesions of Herpes Zoster were noted. These lesions extended from the 12th dorsal spine and followed the nerve root around the lower right chest and stopped at the mid-anterior line. They were exquisitely painful to touch.

This man had suffered an acute coronary occlusion four months prior to being seen for the Herpes. The effects of Banthine on the coronary circulation are not known but as long as he had had a full recovery from the occlusion, it was decided to use Banthine for the treatment of the Herpes Zoster because of the excellent results noted with two previous cases. The dosage was to be kept smaller than usual and therefore he was given 50 mg. every six hours. He returned the next day and stated that after the second dose of Banthine he had complete relief of pain. The lesions on the second day were now non-tender and were beginning to dry. He continued the 50 mg. dosage every six hours and returned the following day. At this time the lesions were beginning to crust over, were very definitely healing and there was absolutely no pain at rest or upon rough rubbing of the area. The medicine was stopped at this time. There were no harmful effects on the coronary circulation as far as could be ascertained. Forty-eight hours after all medication was discontinued, he was still free of pain.

DISCUSSION

Etamon has been successfully used in a series of six patients. From 75 to 100 per cent relief was noted in all. However, because of the side effects of Etamon it has not been considered the drug of choice. Therefore, it was thought that Banthine, being a drug which produces a ganglionic blocking effect, should be effective.

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Feinberg, S. M.: Asthma—Present Status of Therapy, Chicago M. Soc. Bull. 51:1062 (June 18) 1949.

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State Accident Commission Displays Bureaucratic Lapse

Any Oregon doctors who wonder what it might be like under a socialized medicine regime can get a faint idea to satisfy their curiosity by watching some of the performances occasionally staged by the State Industrial Accident Commission. The directive sent to doctors under date of May 7, over the signature of Mr. F. I. Brown, assistant commissioner, is a recent example.

It is not that our state accident commission is not a good one as industrial accident commissions go, or unfair to patient and doctors. For the most part relations between commission and the medical profession usually are about as satisfactory as could be expected under the circumstances.

But occasionally something happens, such as this letter, and usually more irritating than serious, to reveal the commission is not immune against breaking out in a typical bureaucratic rash.

This is probably a good thing. It serves to remind doctors of the existence of the commission as a state governmental agency, while the reaction usually stirred up serves to remind the commission that without the services of cooperative doctors it could be in a bad way.

Reading the letter of May 7, a doctor could not be blamed for getting the idea the commission had concluded the "Bill number plan" described therein was a good thing, and intended doctors to adopt it forth-

with, although in many doctors' offices this would entail additional procedures. The letter stated "we urge your adoption of the plan," and in the next sentence announced, "although bill numbering will first be used on our July voucher, we suggest you begin numbering your bills now so as to facilitate the changeover."

The point is not whether bill numbering is a better method of identifying an account than a patient's name. The point is that, despite machinery maintained by the Oregon State Medical Society to represent them in dealings with the commission, the commission's directive of May 7 was the first most doctors in the state heard of the matter.

Opening the commission's letter was the statement, "The Commission . . . has met with representatives of doctor and hospital groups, and from such meetings developed a simple, effective plan."

From this simple statement a number of doctors assumed the "plan" had been discussed with their official representatives empowered to represent their views, and thought it strange no report of any discussions had been made at the House of Delegates meeting held in Portland on April 28.

A checking of the facts revealed the incorrectness of the assumption. No such meetings were held between representatives of the accident commission or either of the standing committees of the medical society

dealing with industrial affairs, although one of these committees had been requesting a meeting with the commission since late March.

Instead, any commission "conversations" were stated by a spokesman for the commission to have been with individual doctors, or with local groups of doctors including the Salem and Eugene Clinics, and with a number of representatives of hospitals, including Good Samaritan, and Physicians and Surgeons Hospitals in Portland. Finally, on closer questioning, officials of the commission's Salem office admitted the "plan" was developed largely at the urging of hospitals, in an attempt to simplify hospital accounting "problems".

It thus appears that to accommodate hospitals a "plan" was worked out with hospitals, discussed with a small number of doctors or groups of doctors informally, then without more ado promulgated to the entire medical profession of the state. No wonder some doctors, realizing they would be required to handle additional office accounting procedures to benefit the commission—with corresponding additional cost but without additional revenue—made vigorous protest.

Protesting doctors did not question the propriety of the commission trying to develop an accounting plan to accommodate or benefit the hospitals. Their objections were to the fact the commission saw fit to extend this hospital-inspired "plan" to doctors of the state without bothering to mention the proposal to the only channels officially qualified to represent the doctors of the state in dealings with the commission.

In fairness to the commission it should be stated that when questioned regarding the above facts, an official in the Salem office stated they were even then engaged in drafting another letter modifying the "or else" impression which might be conveyed by their May 7 letter, and advising that adoption of the numbering plan would be entirely optional with each doctor. At this writing a copy of the second letter has not been received, but there is little reason to doubt it will make its appearance in due course.

The Oregon State Medical Society for years has maintained a standing committee to advise and confer with the State Industrial Accident Commission concerning its medical care problems, and continues to do so. As a matter of convenience to the commission the chairman of this committee is usually located in Salem or in some city where a commissioner resides. Had the commission in handling the numbering plan request of hospitals seen fit to avail itself of this machinery, instead of lapsing into bureaucracy and taking two letters to announce a plan it claims it intended to be voluntary and optional in the first place but neglected to say so, the current disturbing episode in the commission's relations with doctors could have been avoided.

O. M. W.

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ministration funds. Went so far, also, as to instruct "No part of any appropriation contained in this act shall be used for publicity or propaganda purposes not heretofore authorized by the Congress," and specified cut was to apply to Oscar's own office, not local offices.

Wanna stand up and chee-e-e-r? Well, don't. Not yet, anyway.

Restriction is for *unauthorized* propaganda; kind authorized by Congress is still o.k. And propaganda or publicity is never, never labelled that. No restrictions on funds spent for "education." Finally, federal govt. now spends about \$100 million annually on propaganda.

You still wanna bet Oscar's line will go unpeddled?

Highly Regarded: A.M.A. has cute, though not unusual, method of trying out new delegates, according to information filtering out of recent "relaxation ceremonies" informally held at North Dearborn headquarters.

Seems some top responsible official of House of Delegates, or Trustees, gets confidential report from old reliable committeeman on how newcomers on each committee handle their assignments. Such things as attitude towards witnesses in hearings, type of arguments advanced in private committee huddles, display of judgment shown, ability to analyze proposals, and so forth. New delegates who show ability get tougher, more important (i.e., responsible) committee posts or other assignments.

Question asked about Oregon delegates brought immediate reply. "McLean and McKeown? Two of the best!"

Appropriate Quarters: Wit attending recent annual meeting of Blue Shield and Blue Cross plans in Biloxi hotel maintains scene of business, other meetings, was appropriately called Hurricane Room and correspondent insists hurricane is Big Wind.

No More Doctors: Are you confused? Think of the poor patient who tries to find just a plain medical doctor these days.

Classification recently issued by a branch of defense agency listed among medicals alone no less than *thirty-four* different kinds of physicians! From "allergist" at the top to "urologist" at the bottom the list included 20 "gists," 4 "ists," 2 "ians," 4 "eons" and 4 docs each with an individual label.

Dollar Fun(ds): The Federal Security Agency's Public Health Service (whatta name!) recently compiled figures for congressional use showing funds contributed to states for public health programs for fiscal year 1951.

The portion of these "federal" funds allocated to Oregon is as follows: Venereal disease control, \$40,300; tuberculosis control, \$63,400; general health, \$159,700; mental health, \$32,500; heart disease control, \$21,600; cancer control, \$37,300; water pollution, \$12,100; hospital construction, \$871,797.

Also made available from FSA's Children's Bureau were Maternal and Child Health Service, \$119,166; Crippled Children Services, \$90,988; Child Welfare Services, \$111,743.

Any of this "federal" (i.e., tax-extracted) dough get back into your pockets?

1950 - 1951

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Yonhill County Society	
President, C. A. Bump Newberg	Secretary, H. Shumway McMinnville

Obituary

CLAIREL LEROY OGLE, prominent Grants Pass physician and surgeon, was killed in an automobile accident north of Myrtle Creek, Oregon, on April 27, 1951.

Dr. Ogle was born in Woodburn, Oregon, November 29, 1893. He received his Bachelor of Arts degree at the University of Oregon in 1916. After a brief period of teaching and of service in World War I, he entered the University of Oregon Medical School in 1919. He later transferred to Harvard Medical School where he received his degree in medicine in 1923.

Following two years of internship and residency in Brooklyn Hospital, New York, he came to Grants Pass in 1926 to practice. In 1931, he qualified as a Fellow of the American College of Surgeons.

In addition to being well known throughout southern Oregon as a physician and surgeon, Dr. Ogle was an authority of gemmology. He received a diploma in March, 1950, from the Gemmological Institute of America in Los Angeles, an outstanding honor and achievement.

He was a member of the Josephine County Medical Society, Oregon State Medical Society, American Medical Association and a Fellow of the American College of Surgeons.

Personals

E. S. West, professor and head of the biochemistry department presented a paper at the fourth annual insulin symposium at Indianapolis, Indiana in May. The paper described the results of his research work, largely supported by the Diabetic Research Foundation of Portland.

The insulin symposium is sponsored by the Lilly Research Laboratories as an invitational affair to physicians who have made outstanding contributions to research in the use of insulin. Doctors from as far away as Belgium and England attended.

Carl Larson has been elected vice-president of the Umatilla County Tuberculosis and Health Association. Dr. Larson is head of the Umatilla field station in Hermiston.

Stewart Merrill has moved his offices from Wallowa to Boise, Idaho, where he will engage in general practice. Dr. Merrill has been located in Wallowa for eleven years, except for a period of service in the Medical Corps during World War II. He also was on the staff of the clinic at Enterprise.

Carroll W. Dewey, Grants Pass, has returned to his duties as county health officer. Dr. Dewey has been on leave, completing a public health officer's course for doctors at the University of North Carolina in Chapel Hill.

Leonard M. Kahl, Astoria, is conducting the baby clinic now in operation at Seaside, assisted by Miss Waverly Watson, health nurse. The clinic is sponsored by the Junior Women's Club of Seaside.

News From the Medical School

John Harris, research associate in the Department of Ophthalmology, will become head of the new Ophthalmology laboratory on July 1. Dr. Harris has received a grant of \$30,000 from the John and Mary Markle Foundation of New York, to be used over a period of five years in support of his research work.

Kenneth C. Swan, Professor and Head of the Department of Ophthalmology, has been appointed head of the first laboratory in the Northwest for research and treatment of diseases of the eye, which has been formally opened at the University of Oregon Medical School. The laboratory has been established in memory of John E. Weeks, internationally known Ophthalmologist of New York. Mrs. Jennie Weeks, wife of the late Dr. Weeks, made the major contribution for the new laboratory.

David G. Whitlock, graduate student in the Department of Anatomy, received a Fulbright award for advanced studies at the University of Pisa, Italy. The award is for expenses to and from Italy, scholarship to the University of Pisa for one year, and living expenses for Dr. Whitlock and his family.



WASHINGTON STATE MEDICAL ASSOCIATION



ANNUAL MEETING SEATTLE, SEPT. 9-12, 1951

President, K. L. Partlow, M.D., Olympia

Secretary, J. W. Haviland, M.D., Seattle

Executive Secretary, Mr. R. W. Neill, Seattle

How Did Your Representative Vote?

The past legislative session produced one of the hottest battles over the basic science law in the history of that statute.

The chiropractors had their house bill introduced on the second day of the session, and it came catapulting out of the pro-chiropractic Medicine Committee with a 6-3 do pass recommendation. Legislation introduced before the 15th day of a session must be reported to the floor for consideration, so the Rules Committee was compelled to place the bill on its calendar for second reading. After feeble attempts to amend the bill, it went back into Rules Committee, to remain there until February 16, when the final vote was taken. It lost 56 to 42.

Meantime, lobbyists had worked day and night, and two weeks before the final vote medical association representatives were convinced the tide definitely was in our favor. So confident were these representatives of the outcome, they informed the chiropractic supporters they were beaten, and told members of the Rules Committee they could throw the bill out on the floor for a vote to escape the pressure generated by anti-basic science law forces.

One legislator, who in the past has supported the basic science law, voted for the chiropractic bill last session, presumably because a doctor ran for a house seat in the same district. Two others, who normally could be expected to support the basic science law, voted with their district colleague, who was a chiropractor, for the chiropractor bill. Otherwise, the vote against the chiropractors could have been larger.

Here is the vote on the bill, H. B. 13, with the legislator's county following his name, so you can readily see how your representative voted:

VOTED FOR CHIROPRACTIC BILL: Bailey, Pacific; Bernethy, Snohomish; Brown, Pierce; Brown, Kitsap; Carmichael, Snohomish; Carty, Clark; Connor, King; Dootson, Snohomish; Ford, Kitsap; Hansen, Wahkiakum; Henry, Klickitat; Henry, King; Hess, King; Hofmeister, King; Holliday, Clark; Hoopingarner, Spokane; Huhta, Grays Harbor; Kellogg, Grays Harbor; King, Pacific; Knoblauch, Pierce; Kupa, Pierce; Lorimer, Thurston; Mardesich, Snohomish; McLean, Grant; Miller, Cowlitz; Miller, King; Morris, King; Nunamaker, Whatcom; Olsen, King; Pedersen, Whatcom; Phillips, Grays Harbor; Rasmussen, Pierce; Roderick, King; Sandison, Clallam; Savage, Mason; Simmons, Pierce; Testu, King; Vane, Pierce; Wedeking, King; Wenberg, Snohomish; Young, Kittitas; Hodde, Stevens.

VOTED AGAINST CHIROPRACTIC BILL: Adams, Mason; Anderson, King; Anderson, Chelan; Ball, Spokane; Bassett, Pierce; Beierlein, King; Clark, King; Comfort, Pierce; Cooney, Spokane; Cory, Lewis; Donohue, Columbia; Eldridge, King; Forrest, Whatcom; Frayn, King; Gallagher, Spokane; Giboney, Spokane; Gordon, Whitman; Griffith, Pend Oreille; Hallauer, Okanogan; Hawley, King; Hillyer, Yakima; Hoefel, Adams; Hoff, Pierce; Hurley, Spokane; Jeffreys, Garfield; Johnson, Thurston; Johnston, Spokane; Jones, Douglas; Jones, King; Jones, Spokane; Kirk, King; Lester, Chelan; Loney, Walla Walla; Mayes, Lewis; Neill, Whitman; O'Brien, King; Olson, Franklin; Orndorff, Spokane; Ovenell, Skagit; Paulsen, Pierce; Powell, King; Ridgway, Skagit; Riemcke, Yakima; Schumann, Yakima; Shadbolt, Yakima; Siler, Lewis; Sisson, Skagit; Smith, King; Sorensen, King; Stokes, King; Stonecipher, Walla Walla; Strom, King; Timm, Lincoln; Wintler, Clark; Woodall, Yakima; Zent, Spokane.

Outlook Good for Fair Appraisal of Resolution

As in past legislative sessions, when the chiropractors failed to pass their bill during the 1951 session to exempt them from the present basic science examinations, they presented a resolution requiring investigations and recommendations for the purpose of "improving the laws relating to the issuance of licenses to practice the healing arts."

This resolution was presented in the House by Representatives Rasmussen of Tacoma, Huhta (a chiropractor) of Hoquiam, and Lorimer of Olympia. That is odd company for the Rev. Mr. Lorimer to keep, for Rasmussen and Huhta are enemies of the medical profession.

The "whereas" of the resolution stated, "there have been numerous complaints as to the manner of issuing licenses to practice the healings arts, and a number of bills have been introduced in the present session of the legislature relating thereto." The resolution goes on to command the state legislative council to report its findings to the 1953 session of the state legislature, together with a draft of any legislation proposed.

Heretofore, under similar resolutions, sub-committees of the Legislative Council have been packed with supporters of chiropractors, and hearings held were definitely one-sided. This time the situation is reversed, with Speaker Hodde appointing the follow-

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ing representatives to the committee which will consider the resolution:

Edward F. Riley, Seattle, chairman; Howard T. Ball, Spokane; R. C. Barlow, Tacoma; Wesley R. Eldridge, Seattle; Ted F. Schroeder, Puyallup; Carlton

I. Sears, Olympia; and Max Wedekind, Seattle. Only the last named legislator is definitely prejudiced against the basic science law.

This Committee, therefore, should be able to come up with some constructive ideas.

The Early Birds Get the Reservations

Plans are in the advanced stage for the September convention of the Washington State Medical Association, and hotel reservations are coming in at a pace never before experienced at this early date.

Suites allotted the Association by the Olympic Hotel, convention headquarters, are all spoken for, but double and single rooms are still available in goodly numbers. If those who have not yet made reservations, and who prefer suites, will so signify, your Central Office can obtain them at other near-by hotels.

Edmund Smith of Seattle, who so ably handled the Fishing Derby for two other Conventions, has accepted the chairmanship of that Committee again, and an announcement will be forthcoming in the near future.

Fred E. Cleveland of Seattle has been appointed

by President Partlow as chairman of the Scientific Exhibits, and those desiring exhibit space should contact Dr. Cleveland through the Central Office.

Plans are in the making to hold a physicians' art and hobby exhibit, and those in charge of this activity will be announced in the near future.

Dan Houston, the perennial, and expert golf tournament manager, will have announcements soon on that event. The Seattle Golf and Country course, over which the Association Tournament will be played, has undergone a face lifting, in anticipation of the American Amateur event to be held there, and good as it was, it still will be better and more challenging.

Those who haven't sent in hotel reservations, fill in the blank below and send to 338 Henry Bldg., Seattle.

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Annual Reports Due Soon

The 62nd Annual Convention of the Washington State Medical Association will be held at the Olympic Hotel, Seattle, September 9-12.

Our Constitution and By-Laws require all committee chairmen to submit an annual report to the House of Delegates 30 days prior to the Annual Meeting.

The same requirement applies to memorials, resolutions and proposed amendments to the Constitution and By-Laws.

In order that the Central Office may have time to mimeograph these reports, memorials, resolutions, and proposed amendments, and in turn mail them to Officers, Trustees, County Societies and Delegates, they must be submitted to this office as early as possible, but not later than July 25. They must bear the signature of the individual, officers, or Society presenting them.

Professional Relations Committee Enlarged

In compliance with action by the House of Delegates in annual meeting last September, the Professional Relations Committee of the State Association has been enlarged to include the following members:

Asa Seeds, Vancouver, chairman; A. O. Adams, Spokane; J. W. Bowen, Tacoma; H. F. Brundage, Yakima; Walter C. Moren, Bellingham; Edwin B. Chase, Everett; M. F. Fuller, Aberdeen; W. F. Holmes, Walla Walla; George R. Kingston, Wenatchee; Lawrence A. Schueler, Pt. Angeles; Austin Shaw, Anacortes and Merrill Shaw of Seattle.

This committee is vested with "such powers, as may be necessary for carrying out objectives of the

amended report and the 1943 resolution, and such additional or related duties as may be delegated."

The 1943 resolution required that a committee be authorized to "receive and gather evidence of instances of corporations and unlicensed persons practicing medicine in violation of the law and public policy of the State of Washington, and to dissuade, whenever possible, the persons responsible for such unlawful practice of medicine."

Dr. Seeds' Committee has held two meetings, and another is scheduled with representatives of the State Hospital Association early in June.

State Department of Health

Donald A. Champaign, Longview, will be the acting county health officer of Cowlitz County. He will replace E. L. Van Aelstyn, who has accepted a new position as Clark County Health Officer.

Health officials from eight southeastern Washington counties met in Richland March 14 for the regional meeting of the Washington State Public Health Association. Highlight of the first half of the all-day program was an address by Mr. W. A. McAdams, assistant superintendent of the health instruments division of General Electric at Hanford. McAdams discussed the various aspects of public health involved in atomic radiation. The morning session was completed with a symposium for the health officers and nurses' section on Recent Advancements in the School Health Program. The afternoon symposium on Health Activities in Civil Defense included discussions on The Doctor's Role, the Public Health Nurse in an Emergency, and the Sanitarian on the Civil Defense Team.

W. R. Geidt, head of the laboratories section of the State Health Department, Seattle, announced recently that the present outbreak of rabies in Spokane County may last up to 10 years unless immediate action is taken to stop it. He pointed out that the last serious outbreak of rabies in western Washington "lasted from 1932 to 1942." His comments were made in connection with his reply to a letter written him by A. E. Lien, Spokane County Health Officer.

Dr. Lien protested that local authorities are unable to cope properly with the problem of stray dogs because state officials who imposed the present 90-day antirabies quarantine on dogs have not notified local officials of the extent of their legal authority. Dr. Geidt said the State Health Department is not responsible for enforcement of the rabies quarantine as it was imposed by the State Department of Agriculture.

Tick shots now are available at the city health clinic, Spokane, J. B. Eason, city health officer, announced March 19. The shots are for immunization against Rocky Mountain spotted fever. They are given free to any resident of the city of Spokane, Dr. Eason said. Persons going outside the city to lakes or in the woods are particularly urged to take the shots.

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Medical Notes

Society Meetings

Members of the Cowlitz County Medical Society held a testimonial dinner on April 18. The guest of honor was J. W. Henderson, who retired from the



J. W. HENDERSON

practice of medicine in this community back in 1936. Dr. Henderson was a practitioner in this state for 36 years, giving loyal devotion to his many patients. He came to Longview in 1924 just as the city was being established. In addition to carrying on an active practice, he was a lively citizen, alert to the problems and needs of the community. He served on the city council and later was state senator from Cowlitz County. He helped found Cow-

litz General Hospital and for a number of years took the leadership in its operation. It was appropriate that Dr. Henderson should be singled out for recognition by the medical society. He has been a loyal worker in the field of medicine and has found time to make substantial contributions toward the betterment of his community.

At 79, Dr. Henderson spends a quiet life these days on a comfortable farm in the Eufaula district, where he raises flowers and vegetables and enjoys pleasant hours out-of-doors.

At the May 15 meeting of the Cowlitz County Society, principal speakers were William S. Conklin, Chief of Thoracic Surgery, University of Oregon Medical School and Robert Pulliam of Longview. Dr. Conklin gave an illustrated lecture on heart surgery dealing with congenital and acquired heart conditions. Dr. Pulliam gave a talk on the results of heparin and di-cumoral as anticoagulants.

The Society will meet again the third Wednesday in September.

Clark County Medical Society held its regular meeting at the Organized Reserve Club, Vancouver Barracks, May 1. This was a joint meeting of the medical society and members of the Barnes V. A. medical staff. Following dinner and social hour, a symposium on Diagnostic Procedures was given by

members of the Barnes V. A. medical staff with Reinhard Becker, Chief Professional Services, making the introductions. The program included Master's Two Step Test, Carl A. Petterson, Chief Medical Service; Aspiration Biopsy, John W. Bolen, Chief Surgical Service; Pneumarthrogram in Internal Derangement of the Knee, Warren A. Colton, Jr., Chief Orthopedic Service, and String Test, Millard H. Duxbury, Medical Service.

Members of the Snohomish County Medical Society were guests of the staff of Aldercrest Sanatorium, May 1, for their regular monthly meeting. Charles Mincks reported on the excellent cooperation by the P. T. A. in arranging health examinations of first year children. This is being done as a public service by the doctors and is county wide in scope.

No funds for the medical aspect of civil defense are available, but J. Walton Darrough explained that a well organized plan for medical aid has been formulated. This provides for aid stations, mobile units and general hospitals with the necessary staff assigned.

Speaker of the evening was Thomas P. Geraghty, Seattle, Clinical Instructor in medicine, University of Washington School of Medicine. Dr. Geraghty's subject was Bronchial Asthma and Pulmonary Emphysema.

Auxiliary

Mrs. D. H. Eckles, Richland, was hostess to the Benton-Franklin Counties Medical Society Auxiliary at a book review and tea at her home on February 27. Mrs. L. C. Roos of Richland presented a review of Thomas Costain's newest book, "Son of a Hundred Kings." Mrs. P. F. Shirey, president, conducted the short business session and presided at the silver service during the tea hour.

Mrs. C. L. Calhoun, Hoquiam, was hostess at a luncheon meeting of the Grays Harbor County Medical Society Auxiliary, March 21. The afternoon's program included an address by James Galbraith, county health officer, musical numbers and reports on the midyear conference held recently in Seattle.

Cowlitz County Medical Society Auxiliary met for a dinner meeting at Hotel Monticello, March 21. Hostesses were Mrs. William Johnson and Mrs. Neal Kirkpatrick. Mrs. Mildred Keith Horn, librarian from the Longview Public Library, briefly reviewed some of the new books available at the library. Later the



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group went to the home of Mrs. Johnson for the program and meeting.

Mrs. L. E. Hockett and Mrs. S. P. Lehman were hostesses for the March luncheon meeting of the Clark County Medical Auxiliary which was held in the Officers' Club at the Vancouver Barracks. Mrs. Henry Wiswall, president, presided over the meeting and gave a report of the state board members meeting in Seattle March 2. She reported that the Clark County Auxiliary was one of the most active in the state. Mrs. John Brougher showed movies and slides of the Broughers' recent trip to South America.

Woman's Auxiliary to the Kitsap County Medical Society was held in Bremerton, March 28, at Haddon Hall. Guest speaker was E. Langdon Burwell, Seattle pathologist. His talk covered the development of drugs, particularly the rapid progress of recent years that has culminated in the development of penicillin, streptomycin, aureomycin and others of the antibiotic field.

In charge of arrangements were Mrs. R. Diefendorf, general chairman, and Mesdames C. E. Benson, L. E. Foster, C. L. Salmon, H. A. Barner, Robert Schutt, E. J. Munns and Harold V. Larson.

Election of officers for the coming fiscal year and adopting a project of furnishing a room at the Northern State hospital near Sedro Woolley comprised the major business of the Skagit County Medical auxiliary at its April meeting. Mrs. R. B. Hunter, Sedro Woolley, was elected president of the medical unit in Skagit county. Other officers include: Mrs. L. G. Sharpenberg, Sedro Woolley, vice-president; Mrs. D. R. Hammond, Mount Vernon, secretary, and Mrs. R. M. Anderson, Burlington, treasurer.

Obituaries

DR. ALEXANDER HAMILTON PEACOCK, Seattle, died April 13, of carcinoma of the face. Born in 1880, Dr. Peacock received his medical degree from the University of Pennsylvania School of Medicine in 1901. He began his practice in Seattle in 1905 and was actively engaged up to the time of his death. He served on the American Board of Urology and the American Board of Specialists; was a Fellow of the American Medical Association, Fellow of the American College

of Surgeons, and president of the Washington State Medical Association in 1933.

Dr. Peacock served in World War I as a major in the Army Medical Corps from 1917 to 1919, was a staff member of all Seattle hospitals; founder of the Alex Peacock Urological Group, and was also a member of the North Pacific Surgical Association and the Southeastern Surgical Congress.

DR. WALTER JOHNSTON, 88, early-day Ballard physician and druggist, died March 24 of arteriosclerotic heart disease. A resident of Seattle since 1899, Dr. Johnston was one of the first doctors to practice in Ballard. He also operated a Ballard drug store. He was born in Pennsylvania and was graduated from Jefferson Medical College, Philadelphia, in 1887.

DR. DAVID HARTIN, 59, Spokane, ophthalmologist, died March 9 of myocardial infarction and coronary occlusion. Born in Ottawa, Canada, Dr. Hartin practiced in Nelson, B. C., with his father, before coming to Spokane 26 years ago. He was graduated from McGill University, Faculty of Medicine, Montreal, in 1914 and took postgraduate work in Vienna, London and Budapest.

DR. ROBERT N. HAMBLEN, 66, pioneer Spokane physician, died March 18 of coronary sclerosis and coronary occlusion. Born in Minneapolis, he received his education in Spokane, graduating from the old South Central High School. He received his medical degree at the University of Pennsylvania School of Medicine, Philadelphia, in 1909, and came to Spokane the same year. He was a Fellow of the American Medical Association and a past president of the Spokane County Medical Society.

Diabetes Detection Drive

Diabetes is a chronic disease which can be controlled definitely with diligent treatment and supervision by a physician. Therefore the medical profession for many years has been cognizant of the need for detection and proper care of the undiagnosed diabetic individual.

The American Diabetes Association, now composed of over 1400 practicing and research physicians, was organized originally as a group for the dissemination of data about the disease to the profession.

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However, upon the formation in 1948 of a special Diabetes Detection Committee, the Association assumed the additional function of organizing, directing and financing within their own group a continuing national Diabetes Detection Drive, spearheaded annually by Diabetes Week.

Third year of activity was proclaimed nationally November 12 to 18, 1950. As in the two previous campaigns, physicians, health agencies, press and radio outlets, both nationally and locally, brought before the people the urgent need for early discovery and treatment of the disease.

Each year materials for over 1,000,000 urine tests were distributed by the Association to hundreds of cities and towns which were cooperating in the program. In these communities special committees on diabetes offered free tests to all comers, both in doctors' offices and in specially organized testing centers, or for a small sum the individual could purchase a self-tester at a local drug store.

Among the several hundred thousand tests reported to the Association early in 1950, between half and one per cent were found to be new and previously undiscovered cases of diabetes. Of 200,000 cases specially studied, 3.84 per cent showed positive sugar in the urine tests, and of 120,000 cases actually followed up, roughly 55 new cases among every 10,000 people were discovered.

Prior to the onset of Diabetes Week in November, 1950, members of the Washington Diabetes Association and the Diabetes Committee of the Washington State Medical Association with the aid of the Pharmaceutical Association and the Public Health Service adopted the ingenious St. Louis Strip as a new contrivance for supplemental testing. Over 22,000 of these strips were made available in nearly all drug stores in Greater Seattle and King County alone. They were without charge to anyone who sought to make a test.

The urine carrier worked out by the St. Louis group had the advantage of compactness with the urine specimen dried in a small strip of filter paper, and the sugar which it may contain preserved in a pre-impregnated 2 per cent solution of sodium fluoride. Separating the filter paper from the labelling strip was a small strip of plastic which promoted reading transparency and ease of handling on mass testing and offset the blurring of recorded data by testing solutions.

The three portions were assembled by sewing, with the whole strip known as Drey-pak. It had over-all dimensions similar to those of a lengthened theater ticket. Proper spacing on the strip was provided for the name, sex, age, date and whether or not the individual was aware of pre-existing diabetes. In addition to the strip there was folded in an ordinary size envelope a small slip with printed instructions relative to collection of a post-prandial specimen, dipping the filter paper end of the strip quickly into the urine and out again and then drying overnight. The name and the address of the individual was written on the envelope, which with its contents was returned to the drug store. Mailing had been deferred until the later granting of governmental permission.

About 300 of the parcels could be packed in a shoe box, which points out the compactness of a large number of tests. Besides, weeks may pass without the deterioration of the preserved, dried urine, or until team work is at hand for the mass examination of the strips. Whether sugar is present is determined by dipping bundles of the small filter ends into boiling Benedict's solution for one minute. Known errors have been 10 per cent. These are confined to the faintly positive urines, less than 0.5 per cent of sugar, and in the case of the urine containing 3 per cent or more of sugar contaminating an adjacent negative strip.

Experience in the past two drives revealed that about 12 per cent of the total number of free urine tests which were available for the populace to use during Diabetes Week were utilized. However, figures on the results of the third drive during its recent advent in Greater Seattle and King County where the St. Louis Strip was newly introduced showed a return of 16.4 per cent. One can expect at least 3 per cent of glycosuria in the urines examined. Our recent figures amounted to 3.93 per cent. Roughly, one-third represents old diabetics who are checking on their tests, one-third proves to be glycosuria without hyperglycemia and one-third new diabetics.

The Diabetes Committee has been very much interested in the pilot study for diabetes detection among high school students at Renton. Under the favorable guidance and assistance of the Health Council, the school authorities and the Public Health and school nurses, nearly 2000 boys and girls in nearly equal proportions submitted urine specimens for testing. By using the tablet method in the case of the former, 0.84 per cent showed positive urine tests for sugar, which is comparable with previous expectancies, or about one new diabetic was discovered for every 2,500 tests conducted in children. However, among the girls whose specimens were tested by the St. Louis Strip method, the positive returns were 4.85 per cent or nearly seven times greater than those of the boys.

The Diabetes Committee assumed the task and financing of notifying by mail the results of the urine test to each one who had rendered specimens during Diabetes Week. When the urine test was positive for sugar, it was highly urged that the individual report to the family physician for further testing of urine and blood samples one to two hours after eating a big meal. However, among those who denied having any medical connection, it was urged that these tests be carried out in one or the other of the laboratories. If newly discovered diabetes was ascertained, the individual was referred at random by the Diabetes Committee to any physician who was interested in his proper care.

All members of the medical profession are implored to give their assistance towards carrying out further the detection and treatment of previously unrecognized diabetics throughout the year.

JAMES M. BOWERS, M.D.
Chairman, Diabetes Committee
Washington State Medical Association

Spotlight On Service

Fargher, Gunderson, Segal on Nursing Home Council

Three Washington physicians will be active in the new program of regulating nursing homes, as the result of Senate Bill 189, passed by the recent legislature.

They are Joseph Segal, Seattle, representing the State Association of Licensed Nursing Homes; H. J. Gunderson, Everett, State Medical Association, and C. R. Fargher, Tacoma, Association of Washington Cities. They were recently named members of a ten-man Nursing Home Advisory Council to the State Health Department, as called for in the new law.

The new law has two objectives: First, uniform enforcement of a minimum set of standards of safety and health-care regulations, and second, an educational program which over the years will help raise the standards of nursing home care.

The Department feels that nursing homes will have a vital part to play in the future of health care in this state, especially as chronic diseases are an increasingly larger part of the total illness load. Nursing homes with high standards can be valuable auxiliary facility to hospitals in the care of patients with long-term illness.

Enforcement of the new law is vested in the State Health Department, with cooperation of the State Fire Marshal. If local communities have adequate personnel and other resources, they may request permission to enforce the standards locally.

Sparkman Heads Heart Association

Donal R. Sparkman of Seattle is the new president of the Washington State Heart Association, succeeding

Robert L. King, president since the group was formed three years ago.

New vice-presidents, elected at the association's annual meeting last month, include Joseph Low, Yakima; Robert F. Foster, Seattle and Clement I. Krantz, Seattle. Fred E. Cleveland of Seattle is the new treasurer.

King and Sparkman, together with Mr. Victor Schoch, executive director of the association, plan to attend the convention of the American Heart Association in Atlantic City this month.

Meeting for Diabetic Patients

The Washington Diabetes Association has arranged for an educational meeting for diabetic patients to be held at the University of Washington, July 8. This will be immediately following the Postgraduate Assembly in Endocrinology Including Diabetes which will be held at the Olympic Hotel, July 2-7. Prominent authorities on diabetes will speak to the diabetic patient group and participate in a question-answer period.

Howard F. Root of Harvard Medical School will be moderator. Speakers will include Peter Forsham, Harvard Medical School; Kenneth Swan, Homer Rush, and Blair Holcomb, University of Oregon Medical School; E. Perry McCullagh, Cleveland Clinic; Henry Ricketts, University of Chicago Medical School and Jame Sherrill, Scripps Metabolic Clinic, La Jolla, California.

Lester J. Palmer, Seattle, is president of the American Diabetes Association.

1950-1951 Washington State Medical Association Component Societies

Benton-Franklin Society	President, R. R. DeNicola Richland	D. H. Eckles Richland	Okonagon County Society	President, T. P. Connors Tonasket	Secretary, B. J. Webster Omak
Chelon County Society	President, C. E. Conner Cashmere	First Wednesday—Wenatchee Secretary, F. R. Ellis Wenatchee	Pacific County Society, Third Thursday—Raymond and South Bend	President, O. R. Nevitt Raymond	Secretary, J. C. Proffitt South Bend
Clallam County Society	Second Tuesday—Port Angeles, Sequim President, H. J. Madsen Port Angeles	Secretary, J. J. Fairshier Port Angeles	Pierce County Society	Second Tuesday—Tacomoma President, J. F. Steele Tacoma	Secretary, G. C. Kohl Tacoma
Clark County Society	First Tuesday—Vancouver President, D. R. Loree Vancouver	Secretary, F. M. Butler Vancouver	Skagit County Society	Fourth Monday President, R. R. Rueb Concrete	Secretary, R. Hoag Concrete
Cowlitz County Society	Third Wednesday President, H. H. Minthorn Longview	Secretary, F. D. Morrison Longview	Snohomish County Society	First Thursday—Everett President, J. Meeske Snohomish	Secretary, R. J. Wescott Everett
Grays Harbor County Society	Third Wednesday—Aberdeen President, F. J. Dwyer Aberdeen	Secretary, L. Semler Hoquiam	Spokane County Society	Second Thursday—Spokane President, R. D. Reekie Spokane	Secretary, G. T. Wallace Spokane
Jefferson County Society	President, R. E. Fallis Port Townsend	Secretary, H. G. Plut Port Townsend	Stevens County Society	President, J. E. Blair Chewelah	Secretary, M. B. Snyder Chewelah
King County Society	First Monday—Seattle President, D. Metheny Seattle	Secretary, F. A. Tucker Seattle	Thurston-Moson Counties Society	Fourth Tuesday—Olympia President, R. Highmiller Olympia	Secretary, H. B. Frank Shelton
Kitsap County Society	Second Monday—Bremerton President, H. A. Barner Bremerton	Secretary, F. Rosendale Bremerton	Walla Walla Valley Society	Second Thursday—Walla Walla President, M. W. Tompkins Walla Walla	Secretary, L. O. Carlson Walla Walla
Kittitas County Society	First Tuesday—Ellensburg and Cle Elum President, Arthur Clark Ellensburg	Secretary, Floyd Rogalski Cle Elum	Whotcom County Society	First Monday—Bellingham President, A. G. Zoet Bellingham	Secretary, P. E. Rowe Lynden
Klickitot County Society	President, J. R. Rehal Stevenson	Secretary, D. G. Moody White Salmon	Whitman County Society	Third Wednesday—Colfax President, M. K. Turner Pullman	Secretary, W. S. Butts Pullman
Lewis County Society	Second Monday—Centralia and Chehalis President, Robert Fulton Chehalis	Secretary, Rush Banks Centralia	Yakima County Society	Second Monday—Yakima President, R. D. McClure Yakima	Secretary, W. H. Gray Yakima
Lincoln County Society	President, E. R. Salter Davenport	Secretary, J. E. Anderson Wilbur			

IDAHO STATE MEDICAL ASSOCIATION



**ANNUAL MEETING
JUNE 17-20, 1951
SUN VALLEY**

President, R. T. Scott, M.D., Lewiston

Secretary, R. S. McKean, M.D., Boise

Executive Secretary, Mr. A. L. Bird, Boise

Idaho Governor Vetoes Osteopath Bill

Governor Len Jordan on March 21, 1951, vetoed the Osteopath Practice Act, which had been approved by the 31st Idaho Legislature, his veto message on the bill, written to the Secretary of State, is as follows:

Honorable Ira H. Masters

Secretary of State

Dear Mr. Masters:

"I transmit herewith, House Bill No. 30, by Smith, Murphy, Davis, Brevlow, Bell, Vincent, LaTurner and Storey. While I appreciate the fine training, professional worth, and excellent experience of many osteopathic physicians, and even though I recognize the need for revision of the present Osteopathic Practice Act, I cannot approve House Bill No. 30, for the following reasons:

"1. The Bill is inaccurate in at least one respect: Section 7 provides that "the department of law enforcement may, upon written report and action of the board, waive the requirements of Section 2 hereof," etc. But Section 2 recites "There is hereby enacted Osteopathic Practice Act to be designated and cited as Section 54-1601, Idaho Code.

"Apparently the reference in Section 7 is intended to waive the requirements of Paragraph 'b', Section 4, which has to do with examination of applicants.

"2. The bill is loosely drawn and defective in several respects: 'Nowhere in the bill is there any statutory grounds for revocation or refusal to renew licenses. There is no authority in the department of law enforcement to do anything more than hold a meeting for the purpose of hearing charges.'

"On the other hand, 'the department may, in its discretion, issue temporary permits to practice, valid only until the next regular meeting of the board.' This I regard as a very dangerous power entrusted to the department and especially so when there is no provision in the Act for regular meetings of the Board.

"3. The bill grants to licensed osteopaths, the unlimited right to prescribe the use of drugs and anaesthetics, to practice in any of the fields of medical science except optometry and major surgery. Moreover, the term minor surgery is not clearly defined. The question arises then as to whether applicants should not be required to pass the same qualifying tests as are required of medical practitioners.

"For the reasons above stated, I hereby disapprove House Bill No. 30."

Sincerely,

/s/ Len Jordan, Governor.

Medical Notes

St. Luke's Hospital, Boise, has been approved for courses in Medical Technology, John C. McCarter, Director of Laboratories, reports. He said that the hospital has been fully accredited by the Council on Medical Education of the AMA for course. College of Idaho and University of Idaho, have inspected and approved laboratory for college credits. Both colleges will offer three years' college work which will include the necessary subjects for later entrance in the School of Medical Technology as well as meeting the general requirements for degrees. Students taking the course, will, after three years at college, spend 12 months in hospital for which they will receive full year of college credit.

Governor Len Jordan has announced the appointment of two members of the State Board of Medicine for six-year terms. Re-appointed was W. B. Ross of Nampa. Reed J. Rich of Montpelier, was appointed for a similar term and succeeds H. L. Stowe of Twin Falls.

Robert S. Smith, 312 Idaho Street, Boise, Chairman of the association's Veterans Committee, announces that the V. A. Fee Schedule is being revised. The committee under Dr. Smith's leadership hope to have the revised schedule ready for approval at the June

meeting of the Idaho State Medical Association at Sun Valley.

President Russell T. Scott, Lewiston, has been appointed by Governor Len Jordan as a member of the Hospital Advisory Council to the State Department of Public Health for a six-year term. H. E. Bonebrake of Wallace, is also a member of the council.

North Idaho District Medical Society met at the Bollinger Hotel, Lewiston, April 18. During the first portion of the evening an illustrated talk was given by Thomas Canning, Spokane Urologist. His paper was entitled "Carcinoma of the Prostate."

Two new delegates and alternates for the state meeting were elected for two-year terms. There are three delegates and alternates as holdovers from last year, making a total of five to represent the society at the state meeting. A committee was appointed to clarify the status of Washington State members who desire to be affiliated with the Society.

Three Boise physicians and three dentists have opened a children's medical center in a new, one-story, brick building at 200 East Bannock St. The owners of the new structure include the following:

Frank Fletcher, Robert McKean and Loy Swineheart, pediatricians; Donald Harrison, orthodontist; W. A. Wilson and Dale H. Ablin, pedodontists.

The air-conditioned, fireproof building is of modern design and measures 4,500 square feet. Adjacent to it is a parking lot, along the street side of which a matching brick wall with auto stalls has been built.

Former Governor C. A. Robins, a physician in private life, has joined the North Idaho Medical Service Bureau as Medical Director. Dr. Robins' appointment was effective March 1.

Murland F. Rigby of Rexbury, Chairman of the Idaho State Medical Association's Rural Health Committee, was named a Director of the American Academy of General Practice in San Francisco.

Roscoe C. Ward, Boise, has been appointed by President Russell T. Scott to fill the unexpired term of William A. Abbott, Idaho Falls, as member of association's Industrial Accident Board Committee.

Industrial Accident Board Committee of state association held a meeting in Boise, April 17-18, to begin negotiations to adjust IAB fee schedule. Quentin Mack, chairman, urgently requests recommendations, suggestions and criticisms. Please send them to Dr. Mack, 500 Eastman Bldg., Boise.

Governor Jordan has re-appointed all members of the State Board of Eugenics. Included are:

Edwin Peterson, Boise; Joseph Marshall, Twin Falls; E. R. W. Fox, Coeur d'Alene; Kenneth Collins, Craigmont, and John Wurster of Pocatello.

Association Scientific Exhibits Committee Chairman Charles C. Johnson, Boise, is hoping some of the members of the association are planning scientific exhibits for showing at the 59th annual meeting. Dr. Johnson has asked that you get in touch with him as soon as possible if you are planning such an exhibit. His address: 403 Eastman Bldg., Boise, Idaho. Other members of the Scientific Exhibits Committee you might want to get in touch with include: William T. Wood, Coeur d'Alene; H. R. Fishback, Jr., Idaho Falls; Fred Kolouch, Twin Falls, and John Ayers, Moscow.

Woman's Auxiliary

An executive board meeting of the Women's Auxiliary to the Idaho State Medical Association was held on Tuesday, April 10, 1951, following luncheon at the Hotel Owyhee, Boise, Idaho. Those attending were Mrs. Walter L. West, Idaho Falls, president; Mrs. Hubert E. Bonebrake, Wallace, president-elect; Mrs. Robert S. Smith, Boise, second vice-president and publicity chairman; Mrs. E. D. Parkinson, treasurer; Mrs. Max W. Carver, filer, recording secretary; Mrs. M. F. Rigby, Rexburg, co-chairman of convention, and president of the Upper Snake River District Auxiliary; Mrs. E. L. Soule, St. Anthony, co-chairman of convention; Mrs. L. F. Lesser, Boise, nomination

chairman; Mrs. J. Woodson Creed, Twin Falls, legislative chairman; Mrs. Harmon Tremaine, Boise, revisions chairman; Mrs. Ivan Anderson, filer, president of the South Central Idaho District Auxiliary; and Mrs. Verne J. Reynolds, Boise, president of the Boise Medical Auxiliary.

Most important item of business at this meeting was approval of plans for the state auxiliary convention to be held at Sun Valley, June 18-20, in conjunction with the annual convention of the Idaho State Medical Association. A well-organized program was presented by Mrs. Rigby and Mrs. Soule, convention chairmen.

In the evening of April 10, the regular meeting of the Boise Medical Auxiliary was attended by Mrs. West, Mrs. Bonebrake, Mrs. Rigby, Mrs. Soule, and Mrs. Creed. Mrs. West reported on progress by the state auxiliary this year, and on the National Board meeting of the Women's Auxiliary to the American Medical Association which she and Mrs. Bonebrake attended in Chicago last fall.

Obituaries

Dr. Dan Campbell McDougal, 52, Pocatello, died March 9. Born in Malad, Dr. McDougal graduated from George Washington University in 1927 and had practiced in Pocatello since 1931. He was a member of the Southeastern Idaho District Medical Society, the State Association and the A.M.A.

Dr. William Richard Abbott, 48, Idaho Falls, died of a heart ailment on March 20 after a week's illness. Dr. Abbott was a member of the association's Industrial Accident Board Committee; the Idaho Falls Medical Society; the American College of Physicians and Surgeons; state association and A.M.A. Born in Mountain Home, Dr. Abbott received his Medical Degree from Rush Medical College in 1929.

1950 - 1951

Idaho State Medical Association Component Societies

Beor Lake-Caribou Society	President, H. H. King Montpelier	Secretary, R. Tigert Soda Springs
Bonner-Boundary Counties Society	President, F. Durose Bonners Ferry	Secretary, L. L. Miller Bonners Ferry
Idaho Falls Society	President, D. H. Smith Idaho Falls	Secretary, H. R. Fishback, Jr. Idaho Falls
Kootenai County Society	President, L. J. Frederickson Spirit Lake	Secretary, C. G. Barclay Coeur d'Alene
North Idaho District Society	President, R. Eastwood Lewiston	Secretary, J. H. Bauman Lewiston
Shoshone County Society	President, L. B. Hunter Wallace	Secretary, C. I. Gibbon Kellogg
South Central Society	President, H. F. Holsinger Wendell	Secretary, G. E. Brown, Jr. Twin Falls
Southeastern Idaho District Society	President, R. B. Hegsted Pocatello	First Thursday—Pocatello Secretary, M. M. Graves Pocatello
Southwestern Idaho District Society	President, M. D. Gudmundsen Boise	Secretary, R. R. Jones Boise
Upper Snake River Society	President, H. B. Rigby Rexburg	Secretary, A. C. Truxal Dubois

Medical Meetings

Pacific Northwest Trudeau Society

The Pacific Northwest Trudeau Society will hold its Spring meeting in conjunction with the Washington State Tuberculosis Association at the Spokane Hotel, Spokane, Wash., June 23, 1951. Robert G. Bloch, Chief of the Division of Pulmonary Diseases, University of Chicago School of Medicine, will be the guest speaker.

All interested physicians in the Northwest are invited to attend.

Fifth Congress of the Pan-Pacific Surgical Association

Honolulu, November 7-19, 1951

F. J. Pinkerton, President of the Pan-Pacific Surgical Association, reports that plans are well under way for the Association's Fifth Congress and advises doctors to make arrangements as soon as possible to attend this meeting.

The scientific program, which will begin on Nov. 12 and continue through November 16, will include sessions in all divisions of surgery, with papers presented by topflight surgeons from the Pacific area countries. In addition to attending an outstanding surgical conference, doctors may enjoy a delightful vacation in Hawaii and are urged to bring their families with them, with the assurance of luxurious accommodations.

The Pan-Pacific Surgical Association has been officially appointed as travel agent for those attending

the congress, and it is therefore important that all hotel and travel reservations be made through the Association office, Suite 7, Young Hotel Building, Honolulu, Hawaii.

North Pacific Society of Neurology and Psychiatry

North Pacific Society of Neurology and Psychiatry held its annual meeting April 20 and 21 at Victoria, B. C. Guest speaker was Robert S. Schwab, Boston, Associate in Neurology at the Massachusetts General Hospital and Harvard Medical School. Newly elected officers of the Society are as follows: President, S. N. Berens, Seattle; President-elect, G. B. Haugen, Portland; Secretary-treasurer, Robert A. Coen, Portland; Executive Committee, Gordon Hutton, Vancouver, B. C., W. H. Hutchens, Portland and William Y. Baker, Seattle.

The 1952 meeting will be held in Seattle.

Spokane Academy of General Practice

A meeting of the Spokane Academy of General Practice was held on May 22, Sacred Heart Hospital, Spokane. Guest speakers were Robert P. Sagerson, who spoke on Hospital Radiology; Carol L. Sundberg, who discussed Hospital Pharmacy, and John Hill, whose subject was Pathology Department and the Hospital Laboratory. Two films were shown entitled, Radical Mastectomy and Total Hysterectomy.

**FOURTH ANNUAL
POSTGRADUATE ASSEMBLY
IN
ENDOCRINOLOGY INCLUDING DIABETES
Sponsored by
THE ASSOCIATION FOR THE STUDY OF INTERNAL SECRETIONS
and
THE AMERICAN DIABETES ASSOCIATION
SEATTLE, WASHINGTON • OLYMPIC HOTEL • JULY 2-7, 1951**

The faculty will consist of prominent researchers and clinicians in the field of endocrinology and metabolic disorders.

The course will be a practical one of interest and value to the specialist and those in general practice. The program will consist of lectures, clinics, and demonstrations. Ample time will be given to questions and answers at the end of each session, and registrants are encouraged to contact members of the faculty for individual discussions.

The Olympic, one of Seattle's most delightful hotels, offers special convention rates to members of this assembly. This is an unusual opportunity for you and your family to enjoy a pleasant vacation in the beautiful Pacific Northwest and for you to participate in a highly instructive program of the latest advances in endocrinology and metabolism.

A fee of \$75 will be charged for the entire course and the attendance will be limited to 100. REGISTRATION WILL BE IN THE ORDER OF CHECKS RECEIVED AND WILL CLOSE ON JUNE 4, 1951. Should there be an insufficient number of applicants to fill the course, the registration fee will be refunded immediately in its full amount.

Please forward application on your letterhead, together with check payable to The Association for the Study of Internal Secretions, to Henry H. Turner, M.D., Secretary-Treasurer, 1200 North Walker Street, Oklahoma City 3, Oklahoma, before June 4, 1951. Further information and program will be furnished upon request.

Hotel reservations should be made directly with the Olympic Hotel, Seattle, Washington, and the hotel advised that you are attending this Postgraduate Assembly.

Correspondence

Pocatello, Idaho
April 19, 1951

To the editor:

I think physicians should support such a proposal as the Coudert Law. This law is to permit the postponement of federal income taxes so that that amount of money shall be contributed to retirement funds for physicians. At the present time physicians are being squeezed by the high cost of living without any opportunity to save for the future. The Coudert Bill is to aid these men and women who are not eligible as beneficiaries of corporate or other private pension plans. The worst phase of the present situation as it affects physicians, architects, lawyers, and still other professions is that their earnings are up and down—a lot one year and not so much the next year. The treasury amortizes machinery—why not men?

It is of the utmost importance to encourage young

men to enter professions and small business ventures, but present tax laws, instead of giving encouragement for individual initiative, do the exact opposite by making corporation employment more attractive to young men. I believe this to be against public interest.

I realize the Coudert Bill is, like any other tax law, so difficult you have to hire a lawyer or accountant to understand its working. Nowadays many men who want to save, cannot save. They are not earning what they think they earn, actually they are only an intermediary step between those who pay them and the U. S. Treasury Department.

I think the principle of the bill is very excellent and I would like to read the comments in reply to this letter. I also hope that this attracts the attention of other interested professions. They in turn could influence their congressmen in the bill's passage.

JOHN W. WURSTER, M.D.

Book Reviews

PRIMER ON FRACTURES. Prepared by the Special Exhibit Committee on Fractures in Cooperation with the Committee on Scientific Exhibit of the American Medical Association. Sixth Edition. 109 pp. Price \$2.00. Paul B. Hoeber, Inc., Medical Department of Harper & Brothers, New York, 1951.

This is a small handbook which gives the classification and the general principles of treatment of many of the common fractures. It also has a section on First Aid and gives illustrations of the equipment that should be available for all ambulances and emergency cars.

It presents a good general classification of fractures, the manner in which they are incurred and a good method of treatment in each case. The treatment is for the most part conservative but, where indications warrant, open reductions are suggested. The book presents a concise description of methods of reduction, of fractures and dislocations and means of immobilization. There also are suggestions as to after-care and mobilization of joints and muscles, following the treatment of major types of fractures. In each section there are sufficient warnings of the possible pitfalls and complications and indications are given for calling consultation. It emphasizes the importance of active muscle setting exercises during the period of immobilization.

This small volume is not meant to be a complete discourse on the treatment of fractures but it is an excellent handbook for quick reference, as to classification and method of treatment, of the major fractures.

HARRY E. EMMEL

ESSENTIALS OF OPHTHALMOLOGY. By Roland I. Pritikin, M.D., F.A.C.A., F.I.C.S., Eye Surgeon, Rockford Memorial, Winnebago County and Swedish-American Hospitals, Consulting Ophthalmologist, St. Anthony Hospital, Rockford, Ill. 215 illustrations, including 18

subjects in colors. 561 pp. Price \$7.50. J. B. Lippincott Co., Philadelphia, London, Montreal, 1950.

This is another general book on ophthalmology along the lines of several more well-known works. The author is successful in achieving his aim to present concisely and generally the field of ophthalmology. The volume would be of great value to the general practitioner as a ready reference to the multiple eye problems which present themselves to him before they reach the oculist. To the medical student it would be an excellent textbook.

The volume is divided into two parts. Part one covers the fundamentals of ophthalmology such as anatomy, physiology, extraocular muscles and examination of the eye, spectacles, and a very good chapter on industrial ophthalmology. Part two discusses diseases of the eye grouped according to the various parts of the organ. The book is very well written and contains numerous good illustrations and drawings. For the individual who might wish to follow any subject more thoroughly a bibliography follows each chapter.

F. F. ACKERMAN

NEWER CONCEPTS OF INFLAMMATION. By Valy Menkin, M.D., M.D. Associate Professor of Experimental Pathology, Head of Experimental Pathology, Agnes Barr Chase Foundation for Cancer Research, Temple University School of Medicine, etc. Presented before the Midwest Seminar of Dental Medicine, Maxwellton Braes, Bailey's Harbor, Wisconsin, September 19-23, 1948. 145 pp. Price \$3.50. Charles C. Thomas, Springfield, Ill., 1950.

This little volume consists of a series of four lectures dealing with the general topic of inflammation under the following headings: (1) Capillary permeability in inflammation and the role of the hydrogen ion concentration in the development of the inflam-

matory reaction. (2) The role of inflammation in immunity. (3) Phagocytosis. Chemical factors in inflammation. (4) Diabetes in inflammation. The causes of fever and of leukopenia in inflammatory conditions. Repair.

There is a summary at the end of each chapter and also a condensation at the end of the monograph. It is well illustrated and documented. Some of the ideas expressed are controversial. The author recognizes this and presents the different viewpoints in footnotes, some of which are extensive. In reading the volume, one feels that the author is not trying to sell a "bill of goods." No doubt every physician has speculated on the reasons for the fact that in diabetics the blood sugar level is usually increased in the presence of an inflammatory process. The explanation for this is offered in the fourth chapter.

Since a physician's work is one that deals largely with inflammatory processes, it behooves him to keep abreast of the increased knowledge on this important subject. The more fully he understands the fundamental physiological processes involved in inflammation, the better service he will render his patients. This volume is concise and to the point. It is recommended highly for every physician, to bring him up to date on this topic.

MARTIN NORGORE

ACUTE HEAD INJURY. By Joseph P. Evans, M.D., Ph.D., Associate Professor of Surgery; Director, Division of Neurological Surgery, University of Cincinnati College of Medicine, Cincinnati, Ohio. 115 pp. Price \$2.25. Charles C. Thomas, Springfield, Ill., 1950.

This monograph is number 60 in the American Lecture Series, published simultaneously in the U. S., England and Canada. It is written in characteristic lecture style. The effects of injury produced by external force and by hemorrhage are discussed, principles of treatment are suggested and further illustrated by case reports. Frequent reference is made to the published work of many workers in the field of neurological research and also the clinical experience of outstanding neurosurgeons. The author chooses to divide acute head injuries into four general groups: (1) Scalp injuries, (2) skull fractures, (3) meningeal hemorrhages in its various forms, (4) cerebral trauma.

The first two groups are covered in 25 pages, and 40 pages are devoted to the discussion of the diagnosis, development and treatment of meningeal hemorrhages. Under the general heading of cerebral trauma, the author defines and discusses cerebral concussion, cerebral swelling, cerebral cicatrix and late atrophic sclerosis of the white matter. Each one of the author's groups is adequately illustrated by appropriate photographs of patients, gross specimens or photomicrographs.

The bibliography of 80 authors truly represents a wide coverage of opinion and experience in the field of head injuries. Considering the widespread incidence of head injuries and the fact that only a very few physicians have any opportunity to see more than an occasional case of head injury, this stimulating, provocative and brief review of current knowledge of development and treatment of head injury should

gain very wide acceptance. The style is smooth and informative. The manual has a limp binding and is practically pocket-size and yet inexpensive.

S. N. BERENS

THE USE OF PEDICLE FLAPS OF SKIN IN PLASTIC SURGERY OF THE HEAD AND NECK. By Gordon B. New, M.D., F.A.C.S., Professor of Plastic Surgery, and John B. Erick, M.D., F.A.C.S., Associate Professor of Plastic Surgery, both of Graduate School, University of Minnesota, Minneapolis, and Section on Laryngology, Oreal and Plastic Surgery, Mayo Clinic, Rochester, Minn. 104 pp. Price \$3.00. Charles C. Thomas, Springfield, Ill., 1950.

The authors have done a magnificent job of covering the complex field of the utilization of deformities involving the head and neck. Due to the diversity of ideas and variations in technic of plastic surgeons, this book will do much in creating a more stabilized and less complex method of handling these difficult problems.

The various types of flaps are thoroughly discussed and well illustrated, beginning with pedicle flaps in general, simple pedicle flaps, tubed pedicle flaps and double pedicle flaps. Under each heading is explained the method of planning the various flaps, the preparation of the tube and the manner of transplantation.

A chapter on the factors to be considered in the choice of flaps with the advantages and disadvantages involved is very instructive, giving the basic principles involved that should not be overlooked if one is to obtain satisfactory results from a standpoint of color and texture of skin.

Another chapter deals with the lining of flaps to avoid exposed raw surfaces which in turn will cause contractures and distortion from scarring that will invariably occur. One of the valuable features of this book is the detailed description of elevation, delay and transplantation of flaps which enables one to understand the principles involved by this method which will avoid necrosis by the gradual transferring of the circulation in the flap to the pedicle.

The final chapter deals with pedicle flaps best suited to various defects of the head and neck and, in addition to the detailed basic fundamentals involved, there are many photographs of the excellent results obtained. Even though there are no hard and fast rules governing this type of surgery this book gives a very clear and concise description of the principles that must be considered.

This monograph is written in simple language, is well illustrated and reflects excellent judgment of the authors. It should serve as a useful guide and a valuable asset to any surgeon interested in pedicle flaps of the head and neck.

WALTER S. BROWN

SELECTED STUDIES ON ARTERIOSCLEROSIS. By Rudolf Altschul, M.U.Dr., Professor of Histology, University of Saskatchewan, Saskatoon, Canada. 182 pp. Price \$5.50. Charles C. Thomas, Springfield, Ill., 1950.

This book describes arteriosclerosis from the standpoint of the histopathologist. The author, in an interesting manner, combines certain features of human and experimental arteriosclerosis. Especially outstanding are the sections on Dedifferentiation of Endothe-

lium, the Formation of Foam Cells, and Cholesterosis in Tissues and Organs. The numerous photomicrographs are excellent and reproduced beautifully in detail.

Its value lies in pointing out unemphasized histological features of early arteriosclerosis, in addition to the author's findings in extensive animal research.

AVERLY M. NELSON

HANDBOOK OF MEDICAL MANAGEMENT. First Edition. By Milton Chatton, A.B., M.D., Instructor in Medicine, University of California Medical School, San Francisco; Sheldon Margen, A.B., M.D., Clinical Instructor in Medicine and Research Associate in Medicine, University of California Medical School, San Francisco, and Henry D. Brainerd, A.B., M.D., Assistant Clinical Professor of Medicine and Pediatrics, University of California Medical School, San Francisco. 476 pp. Price \$3.00. University Medical Publishers, Palo Alto, Calif., 1949.

This is one of the best conceived books on medical management that I have read. The book is written in outline form making it exceptionally good for quick reference. The authors have divided the handbook into twenty chapters, each dealing with definition, etiology, diagnosis, treatment, complications, etc., putting emphasis on treatment of various grouped diseases. For example, in diseases of the skin all of the common dermatological lesions are dealt with in regard to their treatment in a concise outline form. Likewise, all of the other systems of the body are grouped with their common and some of the rarer diseases. In addition, essential information concerning intelligent use of chemotherapeutic drugs are included, as well as electrolyte balance, nutrition, etc.

The authors have succeeded in making available a handbook summarizing present-day methods of medical management which will be kept up to date by revised publications.

ROBERT F. ROEDEL

IMMORTAL MAGYAR. Semmelweis, Conqueror of Childbed Fever. By Frank G. Slaughter, M.D. 206 pp. Price \$3.50. Henry Schuman, New York, 1950.

The life of Semmelweis, "Conqueror of Childbed Fever," is portrayed in this brief and readable book. The mortality from puerperal sepsis one hundred years ago was appalling, in some years reaching 20 per cent in teaching hospitals where students carried infectuous material from the dissecting room to women in labor. The methods by which Semmelweis arrived at the solution to this problem are presented in an interesting fashion by the author. When his conclusions were not accepted by Johann Klein, his chief, Semmelweis became bitter at the continuous opposition and left Vienna. He failed to publish his findings for several years, despite the urging of his friends, and this tended to impair the value of his work. Brooding over the needless death of these young women, many of whom he knew himself to be responsible for, eventually contributed to his early death from insanity. The final years of his life were tragically spent in caustic, tactless and stinging letters to those who refused to accept the preventive measures which he had so methodically demonstrated.

The author, formerly a surgeon in private practice in Jacksonville, Florida, gives us a well-documented book and a valuable addition to our medical history.

P. R. ROLLINS

RADIATION THERAPY IN THE MANAGEMENT OF CANCER OF THE UTERINE CERVIX. By Simeon T. Cantril, M.D., Director, Tumor Institute of the Swedish Hospital, Seattle, Washington. 200 pp. 86 illustrations. Price \$5.00. Charles C. Thomas, Springfield, Ill., 1950.

This small volume reviews the important clinical and pathologic features of cancer of the cervix, which bear upon its management by radium and roentgen therapy. The book attempts to put forth an understanding of the management, accomplishments and failures in radiation of the cervix, along with the limitations of radiant energy in combating cancer. The work also evaluates radiation therapy of carcinoma of the cervix, and compares the results to those attained by surgery. The role of x-ray and radium therapy and the technics of application are described in detail, along with problems in dosimetry. A good section of the work is devoted to reproductions of the League of Nations 1937 clinical staging of cervical cancer which are helpful in clinical appraisal of the extent of the disease.

The book is written primarily for radiologists. The technics described are those used at the Tumor Institute of the Swedish Hospital in Seattle. The Stockholm and Paris methods are briefly reviewed. The book reflects the author's personal experiences and ideas, some of which would be agreed to by all radiologists. Any disagreement should not reflect in the over-all survey of the book, which has much excellent data that is of interest to the surgeons and general practitioners in the chapters relating to pathology, spread and the complications of cancer of the cervix. The book contains an extensive, authoritative bibliography and is well indexed and illustrated.

F. E. TEMPLETON

THE DIAGNOSIS OF SALMONELLA TYPES. By F. Kauffmann, M.D., Chief, International Salmonella Center, State Serum Institute, Copenhagen, Denmark. 86 pp. Price \$2.25. Charles C. Thomas, Springfield, Ill., 1950.

This is a monograph of 86 pages in which the author sets forth the basic procedures and criteria for diagnosis and classification of salmonella organisms.

The material deals entirely with laboratory procedure, describing the production and use of antigens and antisera and the preparation and use of cultural media in isolation and fermentation reactions.

The book is well organized, well written and gives clarity to a field that has often proved very confusing.

C. L. HOFF

HANDBOOK OF OBSTETRICS AND DIAGNOSTIC GYNECOLOGY. By Leo Doyle, M.S., M.D. First Edition. 240 pp. Price \$2.00. University Medical Publishers, Palo Alto, Calif., 1950.

This is a pocket-sized handbook of 240 pages. It is well illustrated by Mr. Ralph Sweet. Within the covers are useful tables on such subjects as blood chemistry in the normal and pregnant patient, cardiovascular changes in pregnancy, and so forth. Throughout the text tables are used when it simplifies the presentation of subject material. In the preface the author very



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honestly states, "It is neither a textbook nor a reference book. The information is outlined so that it is easily available and referred to without difficulty." The author has avoided discussion of operative techniques since usually they cannot be presented well in outline form. The section on the emotional aspects of pregnancy is well done and a subject too often omitted from the standard text. The section on the minor symptoms of pregnancy, covering such subjects as nausea, ptialism, pyrosis, leg cramps and pruritis, should be very helpful to many physicians. The section on the Rh factor presents the subject understandably in outline form. This handbook is up to date and should prove to be most useful to medical students, those reviewing the subject for state boards, and anyone who wishes to refresh his memory quickly on the subject matter.

R. K. PLANT

PHYSICIAN'S HANDBOOK. Sixth Edition. By Marcus A. Krupp, M.D., Assistant Clinical Professor of Medicine, Stanford University School of Medicine, etc.; Norman J. Sweet, M.D., Assistant Professor of Medicine, University of California School of Medicine, San Francisco; Ernest Jawetz, Ph.D., M.D., Associate Professor of Bacteriology and Lecturer in Medicine and Pediatrics, University of California School of Medicine, San Francisco, and Charles D. Armstrong, M.D., Clinical Instructor in Medicine, Stanford University School of Medicine. 380 pp. Price \$2.50. University Medical Publishers, Palo Alto, Calif., 1950.

The authors of this book have presented in outline form an excellent reference book dealing with laboratory and clinical aids to be used in all branches of medicine.

The material dealt with is exceedingly practical for both student and physician. All of the useful old and new laboratory procedures are included with their indications and interpretations. Up-to-date information on chemotherapeutic drugs are outlined. Very practical data on electrocardiography, parasitology, hormones, skin tests, fluid and electrolyte balance, and other subjects are conveniently outlined. It is amazing to see how the authors have included almost every useful aid to clinical and laboratory diagnosis in such a small book.

R. F. ROEDEL

CARBON DIOXIDE THERAPY. A Neurophysiological Treatment of Nervous Disorders. By L. J. Meduna, M.D., Professor of Psychiatry, University of Illinois, College of Medicine, Chicago, Ill. 236 pp. Price \$5.00. Charles C. Thomas, Springfield, Ill., 1950.

Meduna, who is well known for his introduction of metrazol convulsive therapy into psychiatry, has now published a summary of his investigations into the use of carbon dioxide inhalation in treatment of psychoneurotics. His thesis, "that function of the cells in the brain must be understood in physiological and biochemical terms, wherefore, a disordered function must be corrected by physiological and biochemical means," underlies his approach.

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of central and peripheral effects of carbon dioxide on the organism for detailed case-reporting, confusion mounts. One cannot help being skeptical of the claims. For example, nearly one-eighth of the text is devoted to one history—of a female homosexual alcoholic in whom treatment was discontinued because of increasing anxiety. There is no evidence of improvement until follow-up reports indicate that she turned to religion. It seems presumptuous to suggest that carbon dioxide narcosis was in any way responsible for her religious conversion.

Most stimulating claim made in this book is for success in treating stutterers. Eleven of thirty-three patients are said to have been cured and ten others improved. Further studies in this group are certainly indicated.

Final chapter on neurophysiologic theory of psychoneurosis is a curious mixture of cybernetics* and metaphysical speculation. We still have a long way to go in unravelling the complexities of human behavior to the point where we are left with "irreducible principles."

NORMAN C. CHIVERS, M.D.

*Cybernetics: Interpretation of human behavior in terms of complicated interconnection of sensitive devices such as employed in the recently developed electronic calculators of extremely complex design.

B. C. G. VACCINATION IN THEORY AND PRACTICE. By K. Neville Irvine, D.M., M.A., B.Ch. Ocon., M.R.C.S. Eng., L.R.C.P. Lond., Medical Superintendent Smith Isolation Hospital, late Pediatric House Physician to the Children's Medical Division of Bellevue Hospital, New York City, etc. Foreword by Konrad Birkhaug, B.A., M.Sc., M.D., F.A.C.P., Chief of the B.C.G. Laboratory, New York State Department of Health. 130 pp. Price \$3.00. Blackwell Scientific Publications, Oxford, England, 1949.

This small book accomplishes well its purpose of reviewing the vast literature on BCG vaccination in a concise fashion, and in addition gives practical details of the technic of vaccination. The author, an Englishman, has done no original work on the subject. However, his position as an interested observer for many years may lend objectivity to his observations. He presents fairly both sides of the many controversial aspects of BCG vaccination. Those who feel that our knowledge of the vaccine, and of immunity to tuberculosis in general is still inadequate, may think Dr. Irvine is not critical enough in his appraisal. He admits he is impressed by the efficacy of the vaccine and favors its use. This favorable attitude undoubtedly colors his interpretations.

Since BCG vaccination is being used more widely throughout the world including the United States, and since tuberculosis is still a great killer, the possibility of producing immunity to the diseases is of interest to all. Favorable reports on the use of BCG in the lay literature will result in increasing questions on the subject by those who may be exposed to the disease. This book will provide answers to most such questions besides being of particular interest to those dealing with tuberculosis and preventive medicine.

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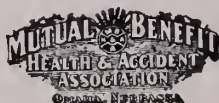
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	Sodium Provided by 60 Gm. Serving	Sodium Provided by 100 Gm.
Beef, without bone	32 mg.	53 mg.
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Table I

SODIUM IN HOSPITAL DIETS⁴

Sodium-Poor Diets*				Very-Low-Sodium Diet†
40 Gm. Protein	70 Gm. Protein	100 Gm. Protein	130 Gm. Protein	70 Gm. Protein
400 mg. Na	500 mg. Na	800 mg. Na	1,000 mg. Na	200 mg. Na

Table II

*Foods prepared and served without salt.

†Weighed diet. May contain 4 oz. of unsalted meat.

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1. Wheeler, E. O.; Bridges, W. C., and White, P. D.: Diet Low in Salt (Sodium) in Congestive Heart Failure, J.A.M.A. 133:16 (Jan. 4) 1947.

2. Wohl, M. G., and Schneeberg, N. G.: Dietotherapy (Cardiovascular Disease), in Jolliffe, N.: Tisdall, F. F., and Cannon, P. R.: Clinical Nutrition, New York, Paul B. Hoeber, Inc., 1950, chap. 27.

3. Bills, C. E.; McDonald, T. C.; Niedermeier, W., and Schwartz, M. C.: Survey of the Sodium and Potassium Content of Foods and Waters by the Flame Photometer, Fed. Proc. 6:402 (Mar.) 1947.

4. Mayo Clinic Diet Manual, Philadelphia, W. B. Saunders Company, 1949, p. 113.

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1. Clark, Le M.: The Vaginal Diaphragm. St. Louis, C. V. Mosby Company, 1938; p. 43.
2. Dickinson, R. L.: Techniques of Conception Control. Baltimore, Williams & Wilkins Company, 1950; p. 17.



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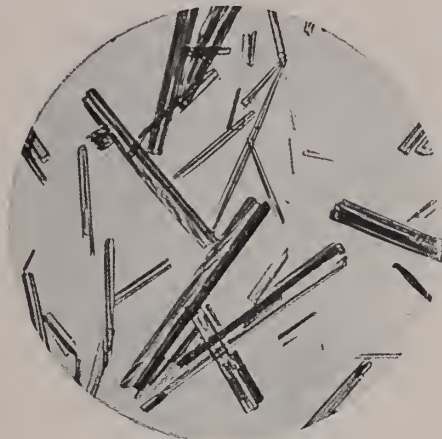
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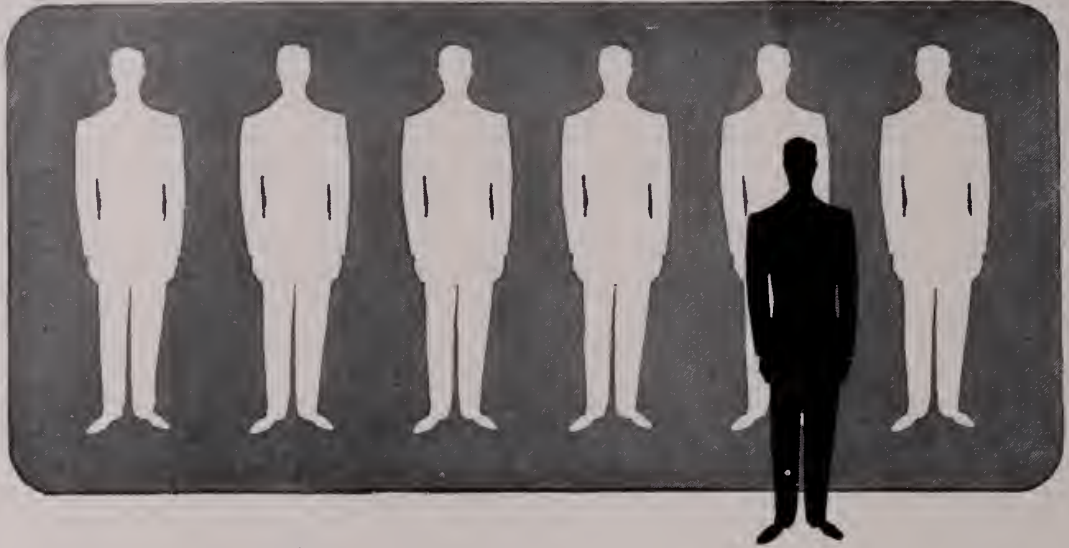


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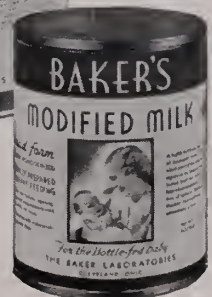
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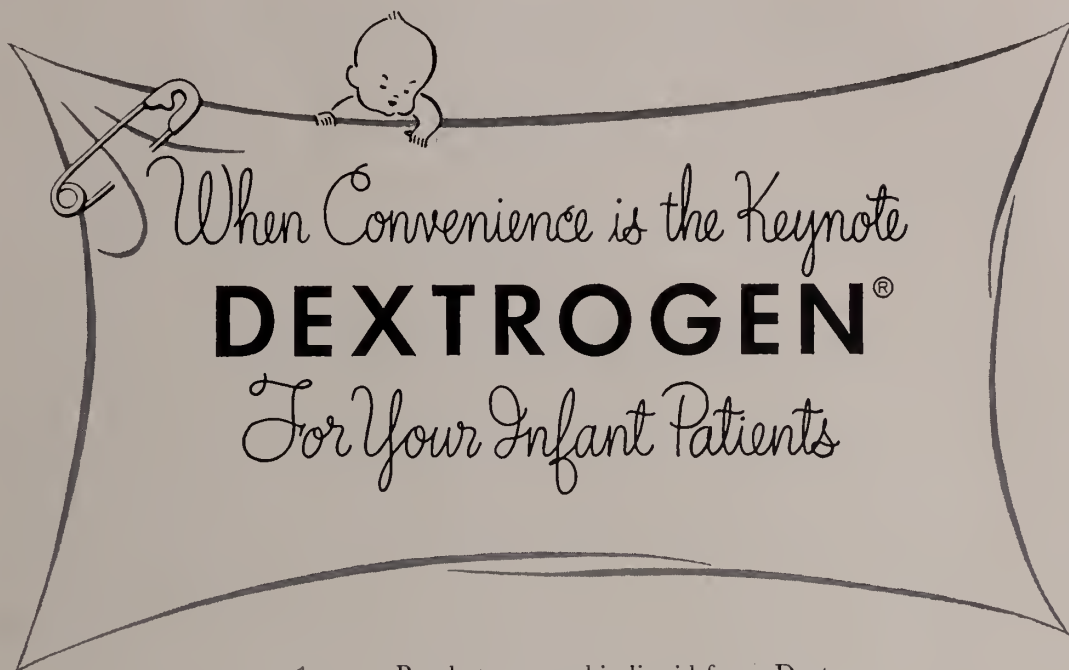
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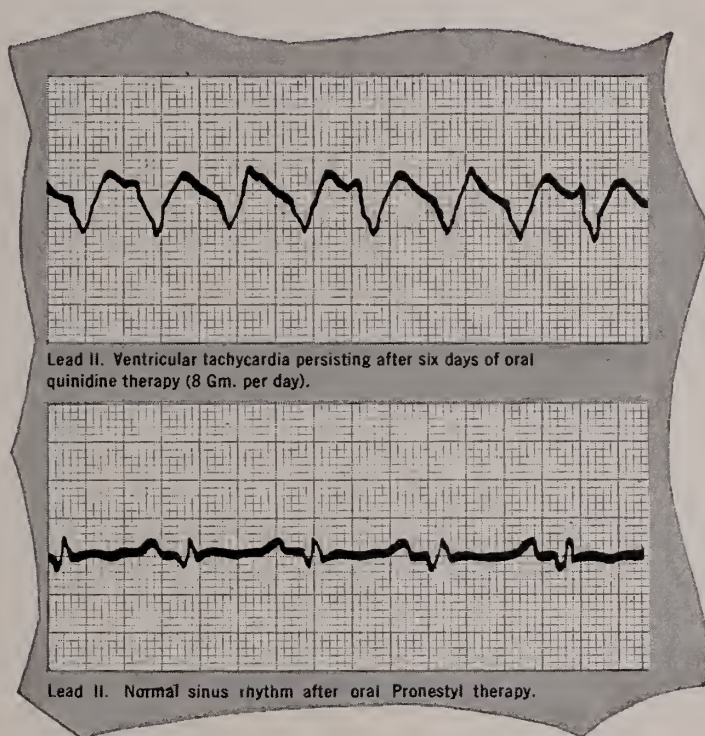
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1. Douglas, R. G.; Ball, T. L., and Davis, I. F.:
California Med. 73:463 (Dec.) 1950.

2. Pratt, P. T.: Nebraska State M. J. 35:294 (Sept.) 1950.

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Oregon State Medical Society.....Portland, Oct. 10-13, 1951
President, W. J. Weese Secretary, R. F. Miller
Ontario Portland

Washington State Medical Association.....Seattle—Sept. 9-12, 1951
President, K. L. Partlaw Secretary, J. W. Haviland
Olympia Seattle

Idaho State Medical Association.....Sun Valley—June 17-20, 1951
President, R. T. Scatt Secretary, J. A. McKean
Lewiston Boise

Alaska Territorial Medical Association,
Ketchikan—May 31-June 2, 1951
President, D. Cramer Secretary, W. P. Blanton
Ketchikan Juneau

PERIODICAL SOCIETY MEETINGS

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North Pacific Orthopedic Society.....Sun Valley—May, 1951
Secretary, J. K. Burtan President, W. H. Goering
Boise Tacoma

North Pacific Surgical Assn...Vancouver, B. C., Nov. 16-17, 1951
President, S. F. Herrmann Secretary, J. A. Duncan
Tacama Seattle

OREGON

Central Willamette Society.....Second Thursday
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Oregon Academy of Ophthalmology and Otolaryngology—Third
Tuesday, Old Heathman Hotel, Portland
President, R. S. Fixatt Secretary, G. E. Chamberlain
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Oregon Pathologists Association, Second Wednesday—Portland
President, V. D. Sneed Secretary, J. E. Nahlgren
Portland Portland

Oregon Radiological Society—Second Wednesday—University
Club, Portland
Secretary, C. T. Jessell
Portland

Portland Academy of Pediatrics.....First Monday
President, S. G. Babson Secretary, Edward Rectar
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Portland Surgical Society.....Last Tuesday
President, J. M. Roberts Secretary, J. W. Nadal
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Southern Oregon Society.....May, 1951—Klamath Falls
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Klamath Falls Klamath Falls

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.....Third Tuesday—Seattle or Tacoma
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Seattle Gynecological Society.....Third Wednesday
President, C. D. Kimball Secretary, Robert Plant
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President, W. A. Jaquette Secretary, G. E. M. Adkins
Seattle Seattle

Seattle Psychoanalytic Study Group.....First Thursday
President, Gert Heilbrunn Secretary, E. W. Haertig
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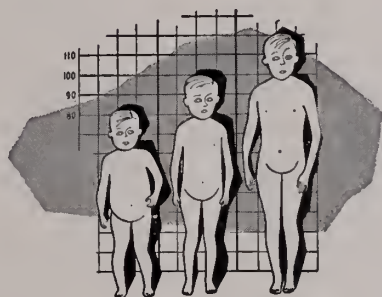
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Washington State Society of Anesthesiologists.....Fourth Friday
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Vol. 50

JULY, 1951

No. 7

Attention, Please!

Fate of Aged in Mental Hospitals—Levy and Southcombe

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A. M. A. Convention News Briefs—Washington Section

Recent Advances in Gynecology—Reekie

Care of Traumatic Wounds—Matthews

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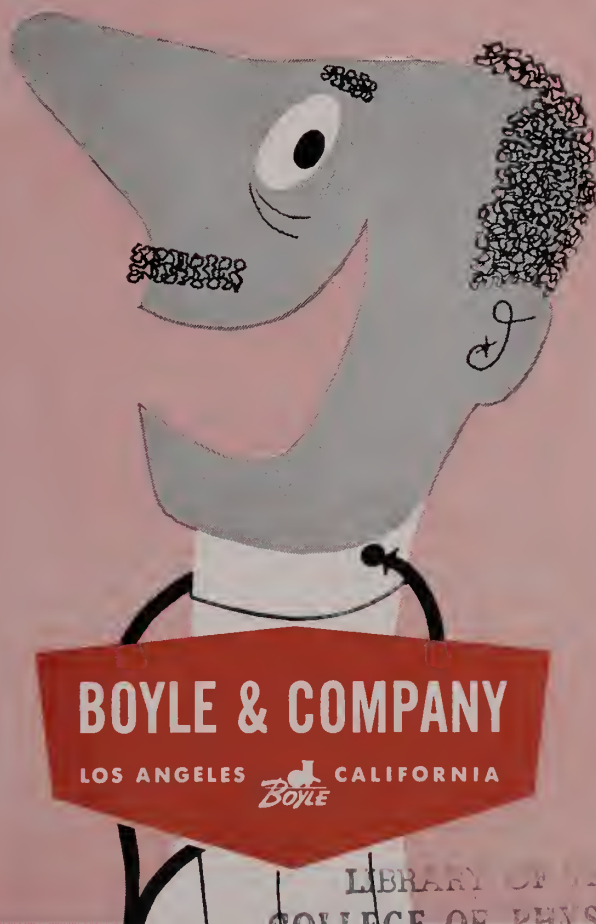
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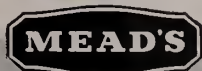
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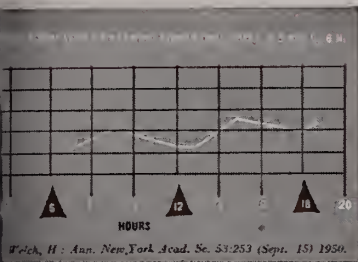
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ANDROMACHI

LAST MONTH'S MEETING of the A.M.A. was not exactly a record buster but it brought a total of 28,396 persons to Atlantic City. Most important matter considered by the House of Delegates was that of hospital standardization. Result was a compromise with details left to a committee of six members from the A.M.A., six from College of Surgeons, six from College of Physicians and six from American Hospital Association. Best safeguard to preservation of medical standards is fact that Elmer Henderson heads A.M.A. section of the committee. During the argument he was invited to include himself out. His answer was a good round Hendersonian NO. They should have known that it isn't that easy to get Elmer Henderson to quit fighting.

GENIAL DWIGHT MURRAY of Napa, Calif., succeeds Louis Bauer as chairman of the Board of Trustees. He deserves the honor, having worked long and hard for the benefit of the profession.

JOHN CLINE's inaugural address was up to the usual Cline standard. One of the most articulate presidents in a good many years, his impact this year as the leader of American medicine should be considerable.

He will have to keep busy indeed, however, if he follows the schedule which Elmer Henderson has kept since his inauguration at San Francisco in June last year. It is doubtful if any one person has ever worked as hard or done as much for the American Medical Association in a single year.

THE EDITORIAL OFFICE has received some very nice comments recently regarding a change in policy of advertising acceptance. It is pleasant to get letters like the one from Lambert D. Johnson, Jr., of Mead Johnson and Company. After noting receipt of our announcement he says: "We here at Mead Johnson & Company have always felt that NORTHWEST MEDICINE is one of the finest medical journals in the country and we wish to assure you of our hearty, continued support."

In return we might say that we have long admired the consistent, sustained program of quality advertising which has characterized the message presented to the profession by Mead Johnson. They are high on our list of favorite advertisers.





Two of these physicians suspected the worst...

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(Brand of Pyrilamine Maleate)
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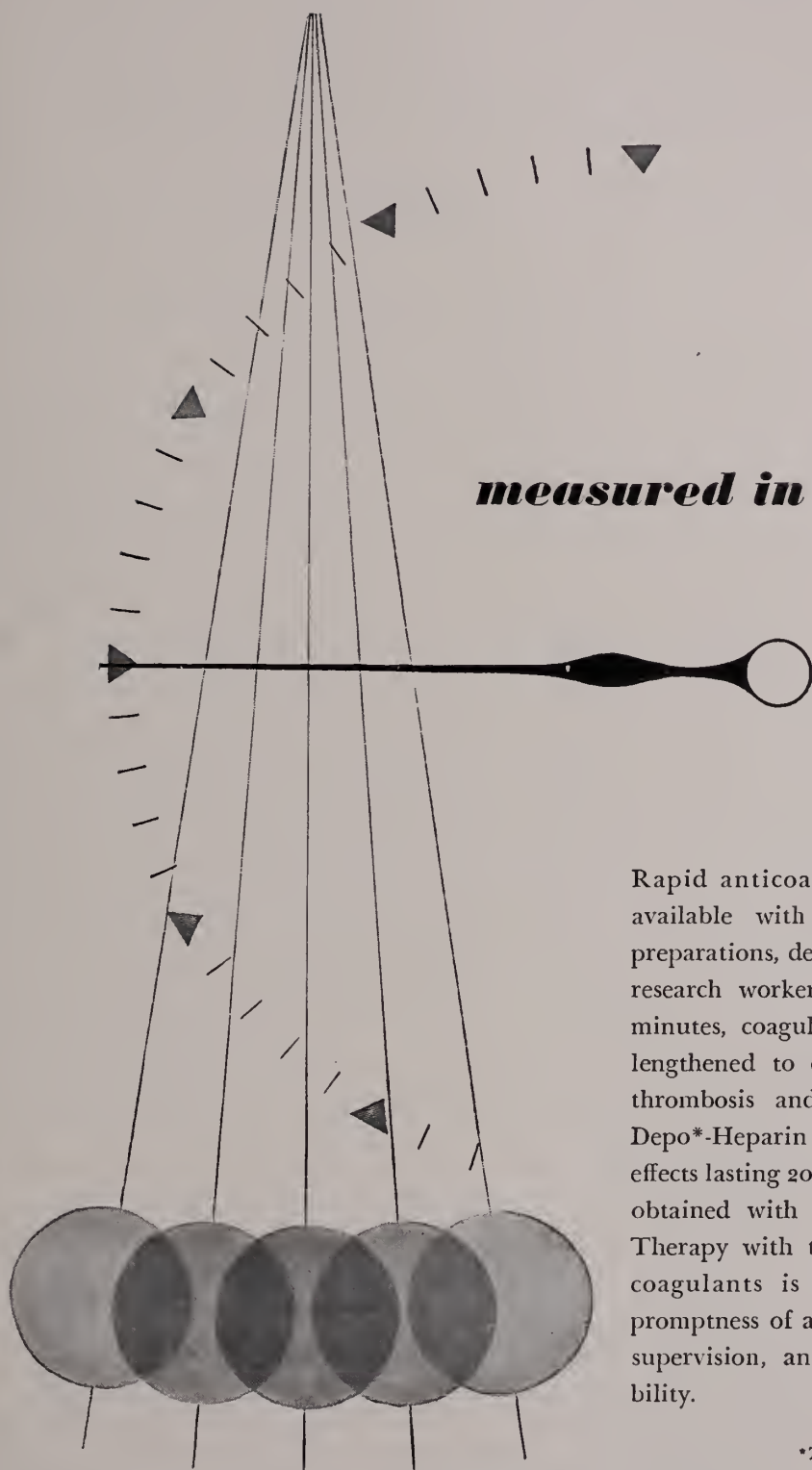
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MEAT in the Dietary Treatment of Ulcerative Colitis...

Of utmost importance in treating ulcerative colitis is the support of the nutritional state of the patient with a diet providing generous amounts of protein, vitamins, minerals and calories but giving a minimum of intestinal residue.^{1,2} Studies have shown that the most urgent nutritional need is for protein.³ Other investigations have disclosed that patients with colitis display abnormally low serum levels for almost every vitamin.⁴ Since most of these patients have anorexia, tempting food is essential for stimulating the appetite.

In particular, meat offers distinct advantages in maintaining the nutritional status and vigor of the colitis patient. Meat furnishes an abundance of protein, B complex vitamins and iron. Its protein contains all the indispensable amino acids in biologic proportions for growth and repair of tissues. Its B vitamins include thiamine, riboflavin, pyridoxine, niacin, and the recently discovered B₁₂. Being almost completely digestible, meat yields negligible intestinal residues which are non-irritating and non-stimulating to the intestinal musculature.

Another feature of meat in the diet of the patient with ulcerative colitis is its appetite-stimulating value for overcoming anorexia and promoting the digestive processes. In a widely used low-residue colitis diet,² providing from 60 to 80 Gm. of protein, 120 Gm. of meat and 10 Gm. of crisp bacon are included.

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The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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NORTHWEST MEDICINE

VOL. 50, No. 7

JULY, 1951

\$3.00 Per Year

EDITORIALS

Idaho's Meeting an Outstanding Success

Annual meetings of the Idaho State Medical Association follow an unique pattern. It is characterized by high quality instruction, intensely practical in nature, delivered by selected speakers in an atmosphere conducive to good postgraduate instruction. The 59th session, concluded last month, was fully up to standard if indeed it did not set a few new marks. In registration it did break all records. Almost half of the Idaho membership was registered. Out-of-state registration was substantially greater than ever before.

Attendance at scientific sessions was far heavier than at previous meetings. This was no doubt aided by wise decision of the program committee to limit instruction period to the forenoons, leaving afternoons open for recreation. Result was aptly described by one of the guests, who stated that Idaho had developed one of the most pleasant ways of absorbing postgraduate education he had yet encountered.

Speakers, without exception, had prepared their messages in concentrated form and had selected subjects almost entirely applicable to every-day practice. Summaries of a number of the talks will be published in the August issue of NORTHWEST MEDICINE. Group discussions at luncheon were discontinued this year in favor of a single round-table question and answer period, including all guest speakers. This was held on the final afternoon of the meeting. Response to this innovation indicates that the practice will be continued in subsequent sessions.

Socially the meeting was well planned. The outdoor dinner Monday evening was staged a little earlier than usual and concluded before the evening chill became uncomfortable. Annual stag dinner Tuesday evening was in the traditional buffet style with an elaborate table of excellent food. Ladies' dinner on the same evening was a duplicate of that provided for the men. Wednesday evening saw the

annual banquet as the concluding event of the session.

Meetings of the House of Delegates were held Sunday afternoon, Monday and Tuesday mornings. Business was conducted smoothly by President Scott. No controversial issues came before the organization. Highlight of the House sessions was the report of the A. M. A. meeting by H. B. Woolley. He presented not only actions of the A. M. A. House of Delegates but also discussed background facts and gave information on current activities of the national body.

The following officers were elected for the ensuing year: President-elect, Wallace Bond, Twin Falls; Secretary, Robert McKean, Boise; Councilor, First District, Alexander Barclay, Coeur d'Alene; Councilor, Fourth District, E. V. Simison, Pocatello. To fill the unexpired term of Dr. Bond, Councilor, Third District, C. B. Beymer, Twin Falls. Delegate to A. M. A., H. B. Woolley, Idaho Falls.

Nominated to the Board of Trustees, NORTHWEST MEDICINE, two-year term, Walter West, Idaho Falls; three-year term, D. M. Loehr, Moscow.

At the Annual Banquet A. L. Popma of Boise was installed as president. The meeting next year will be held June 15-18.

Unique pattern of Idaho's annual meetings is apparent, year after year. Instruction is practical. It is given by speakers selected because of their ability to present material clearly and well. There is a nice mixture of social activities with the more serious purposes of a medical meeting. Cordial hospitality of Idaho physicians is traditional. Those who have never attended one of these sessions should plan now to attend next year—they have a pleasant experience in store. Those who have attended in the past will be looking forward to another enjoyable session in 1952. Idaho meetings are always successful.

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

A New Journal--Antibiotics and Chemotherapy

It is not surprising that the fast-growing field of antibiotics and chemotherapy has reached the stage of needing a publication all its own. It is a pleasure, therefore, to welcome *Antibiotics and Chemotherapy* to the fold of medical publications. Volume one, number one, was issued by the Washington Institute of Medicine in April. It is published in a Spanish as well as an English edition. Editor-in-Chief is Henry Welch, Ph.D., of the Food and Drug Administration. International editor is Felix Marti Ibañez, M.D., of New York. The large editorial board lists many names of well-known researchers in all parts of the world.

First issue carries fifteen articles including two on new antibiotics, Fumagillin and Rhodomycin. There is an interesting paper on present status of antibiotic therapy and two on the increased growth rate of animals fed antibiotics. Others are on clinical investigation of various antibiotics and some are reports of laboratory research.

The new journal is well-printed on good quality paper and is carefully edited. It has entered an interesting and rapidly expanding field. It gives promise of becoming a most useful publication.

Lay Group to Benefit A.M.A. and the Public

The A.M.A. opened the door a little wider and stepped firmly out of the ivory tower last month during the meeting at Atlantic City. Louis H. Bauer, formerly chairman of the Board of Trustees and now president-elect, made the announcement for the board. A committee of laymen will be invited to confer with the A.M.A. on medical matters affecting the general public. Prominent individuals representing groups such as industry, labor, agriculture, education, the clergy and the bar will be asked to participate.

This is a wholesome move. Physicians have long been accused of talking to themselves too much. Now the profession will have the benefit of unbiased,

honest opinions from a group subservient to no one and interested only in the best of medical care for all the people. It is interesting to note that selection of members for this committee will be made only from those not engaged in politics.

Dr. Bauer stated that the Board of Trustees considered this move to be in continuation and expansion of its policies in the field of public relations. Since it can become both useful and beneficial to the organization as well as the public, it is indeed a wise move into public relations of the highest type. Its success seemed assured with its announcement.

National Doctors Committee for Improved Federal Medical Service

We used to be called a nation of joiners. It now appears that it would be more appropriate to call us a nation of committee makers. Day by day the list of committees for the promotion of something or other grows longer and longer. But every once in a while one comes along which seems to make a reasonable amount of sense. Latest is the National Doctors Committee for Improved Federal Medical Services.

Literature from this organization states that it is an affiliate of the Citizens Committee for the Hoover Report. Quotes from the Hoover Report are used in explanation of what the committee is trying to do. "(The Hoover Report) disclosed that federal medical services are: Unorganized, uncoordinated, unsupervised—without over-all planning. Disastrously competitive and wasteful with tax dollars and scarce professional talent. Unprepared and

unable to mobilize hospital facilities, medical supplies, or skilled medical manpower to meet any emergency . . . Five major and thirty smaller federal medical agencies operate completely independently of each other. There is unhealthy and excessive competition among them for doctors, nurses and technicians. No one in our \$70,000,000,000 government has the responsibility for an over-all plan."

Purposes of the committee are to unify all federal medical activities, insure utilization of buildings and equipment, coordinate purchase, storage and distribution of supplies, coordinate, nationwide, the medical measures necessary to national defense. Other suggestions of the Hoover Report are included in the program.

Headquarters of the new committee are at 15 West 46th Street, New York 19, N. Y.

ORIGINAL ARTICLES

Fate of the Aged Hospitalized for the First Time in a State Hospital for the Mentally Ill*

SOL LEVY, M.D., and R. H. SOUTHCORBE, M.D.†

MEDICAL LAKE, WASH.

IMPROVEMENT in medical care and general living conditions have definitely lengthened the average span of human life. Each year a greater percentage of the population reaches advanced ages and statistics indicate that this trend will continue. Consequently, there are constantly increasing numbers of people liable to degenerative changes, especially in the central nervous system. In certain of these people impairment in the central nervous system is great enough to produce serious emotional disturbances, paranoid delusions, advanced deterioration or difficult behavior problems. These patients are usually admitted to a psychiatric hospital. They undoubtedly need and deserve the treatment and protection that is provided only by such a hospital setting.

However, the majority of elderly people will have only mild memory defects, slight confusion and the somewhat more exaggerated deterioration characteristic of the aging process. Their medical care and disposition presents much more complicated problems than those of the first group and, unfortunately, are not solved adequately at present. Although the public mental hospitals have been called upon to care for this increasing number of older patients, this group of elderly patients presents a problem in itself within the institution.

As will be shown in this paper, despite the poor psychiatric prognosis, the problem presented by these patients is, to a considerable extent, limited by an increasingly poor physical prognosis with relatively short survival time in the hospital. In other words, these patients do not present any burden of magnitude individually to the state hospital but rather collectively on the basis of numbers in institutions all too generally overcrowded.

During recent years admission rate of the aged, that is, patients 65 years of age and over, to institutions for the mentally ill has increased considerably. At Eastern State Hospital in 1933 the percentage of these patients admitted for the first time in their lives to a state institution for the mentally ill was 16 per cent, while in 1948 the percentage

of admissions for the same group was 34 per cent and for 1949 it was even higher. For the period from 1891, when the hospital was opened, until December 31, 1948, when the study was completed, the average percentage of admissions of patients 65 years of age and older was 21 per cent, or more than one-fifth of the total admission rate. As can be seen, this problem has been a considerable one during recent years and, in order to do proper planning of hospitalization for such patients, information is required as to their course and adjustment in the hospital, the eventual prognosis and their expectancy of hospital life.

In Table I the total admissions of patients 65

	Male	Female	Total	Percentage
65 to 69	540	248	788	27.3
70 to 74	529	227	756	26.2
75 to 79	428	209	637	22.1
80 to 84	292	162	454	15.7
85 plus	178	70	248	8.7
Total	1967	916	2883	100.0
Per cent	68.3	31.7	100%	

years of age and older is broken down into various age subgroups at five-year spans. Altogether 2883 patients were admitted during this 57-year period, of whom 1967, or 68.3 per cent, were males, and 916, or 31.7 per cent were females. Almost one-half of the 2883 patients, when first admitted to Eastern State Hospital, were 75 years of age and older. This latter finding is almost to the point in agreement with the findings of Camargo and Preston¹ in their survey on the elderly patients in Maryland institutions in 1945.

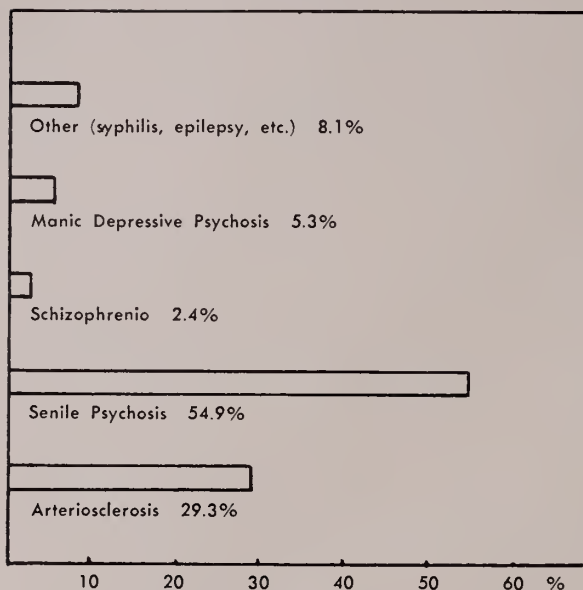
Chart I shows the final diagnostic classification and it can be seen that more than half were grouped into the various types of senile psychoses and more than one-fourth as psychosis with cerebral arteriosclerosis. The remaining patients fell within the various diagnostic groups. However, as can be seen, the major psychoses such as schizophrenia and manic depressive psychosis were represented only in a small number. Camargo and Preston¹ in

*Read at the Sixty-first Annual Meeting of Washington State Medical Association, Spokane, Wash., Sept. 10-12, 1950.

†Eastern State Hospital.

1. Camargo, O. and Preston, G. H.: What Happens to Patients Who Are Hospitalized for the First Time When Over 65 Years of Age. *Am. J. Psychiat.*, 102:168-173, Sept. 5, 1945.

CHART I
Final Diagnosis

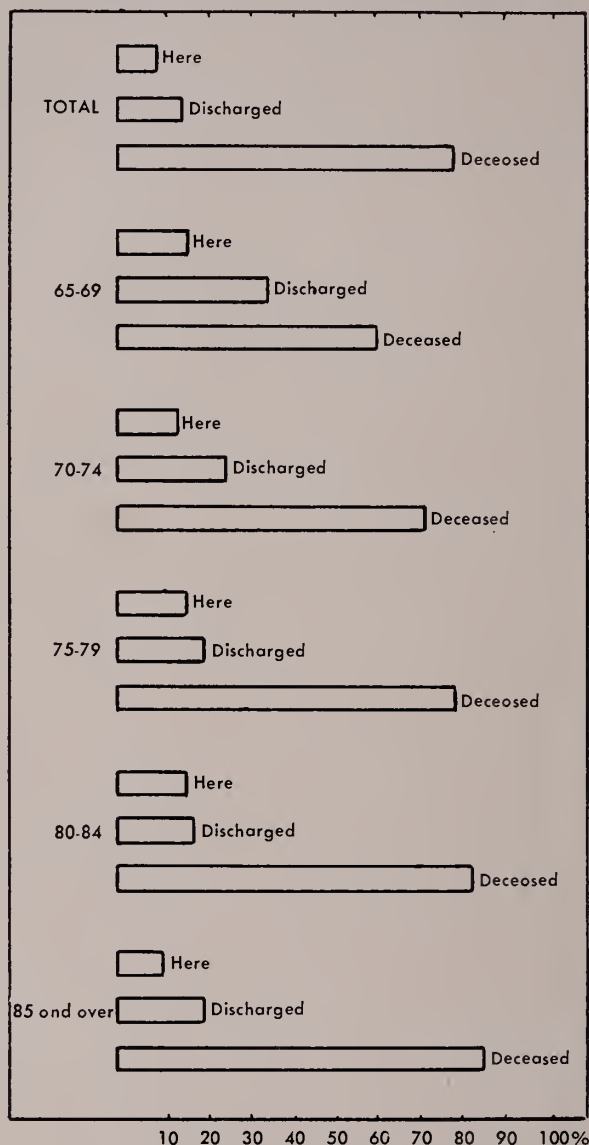


their report state that 85 per cent of their patients were classified as psychosis with cerebral arteriosclerosis and senile psychosis. In our study the two diagnostic groups represent 84.2 per cent of the total. There seemed, however, still some controversy over placing patients into these two diagnostic groups. We have reports, mainly those coming from the New York State Department of Mental Hygiene,² considering the problem in the New York state mental institutions showing a higher percentage of cerebral arteriosclerotics, while the seniles are less frequently represented. Placing the patients into one or the other diagnostic category has always been a difficulty in diagnostic classification and this seems to be entirely dependent on the individual examiner. It is, however, of interest to note that these two groups within the survey of the New York state institutions represented a total of 82.4 per cent.²

In Chart II all the patients are classified according to their dispositions (discharge, still hospitalized, death). As is expected, more than three-fourths have died, while approximately one-sixth have been discharged and a little less than one-twelfth are still hospitalized. This chart also shows the same disposition for the various age spans and, as would be expected, the higher the age on admission the greater the death rate and the smaller the discharge rate.

If death rate is compared with total admission rate of the 65 years and older patients, Chart III, it shows that 21.4 per cent were dead within the first month; after three months almost one-third, or

CHART II
Classification of Patients 65 Years of Age and Older in Regard to Death, Discharge, Still Hospitalized



32.5 per cent of the total admissions had died, while after twelve months almost one-half of all the admissions in this age group were dead. This is a significant fact since it shows that within the first month more than one-fifth of the patients admitted for the first time to the state institution when 65 years of age and older, had died, while at the end of one year almost 50 per cent had died. These figures again are in close agreement with the study done in Maryland, where 57 per cent of the patients admitted to the hospital for the first time when they were 65 years of age and older had died.

In Table II the length of stay of patients in the hospital prior to death has been noted according to the age groups and sex. Altogether, 2170 of the 2883 patients (75.2 per cent) have died. Out of these, 617 (28.4 per cent) deaths occurred within

2. Malzberg, B.: Statistical Analysis of Ages of First Admissions to Hospitals for Mental Disease in New York State. *Psychiatric Quart.*, 23:344-366, April, 1949.

CHART III

Death Rate in Percentage to the Total Admission Rate of Patients 65 Years of Age and Older During Various Months Following Admission

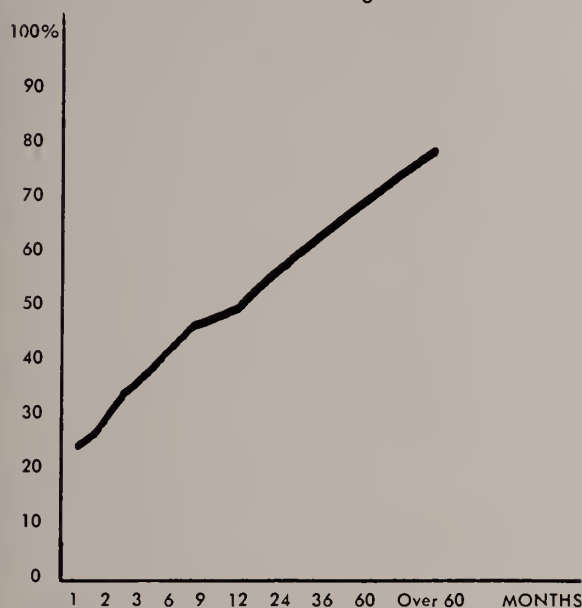
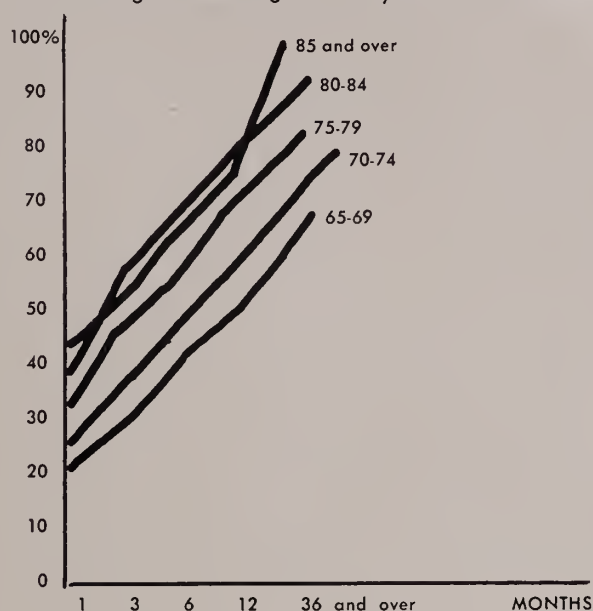


CHART IV

Death Rate in Percentage of the Various Age Groups According to the Length of Stay Prior to Death



the first month of hospitalization. Another 193 of the deaths occurred between the first and second months, indicating that 37.3 per cent had died within the first two months of hospitalization. Another 129 died between the second and third months of hospitalization, indicating that 43.2 per cent of the deaths occurred within three months after admission. Another 203 patients died between three and six months, showing clearly that more than one-half of the deaths occurred within the first six months of hospitalization. Within the first year approximately two-thirds had died.

In Chart IV the death rate in percentage of the various age groups according to the length of stay prior to death in the hospital was noted and it certainly justified the expectation that the older the patient on admission the sooner he died. In other words, within the first month the greatest

number of deaths occurred within the group 85 years of age and older, while the group of 65-69 years had the smallest number of deaths. This trend holds true for the entire course of hospitalization.

Chart V shows the principal cause of death and from this it will be seen that almost one-fourth of the patients died from arteriosclerotic heart disease, while another one-fifth died from pneumonia, approximately one-eighth died from exhaustion while one-tenth died from cerebral hemorrhage. It is interesting to note that exhaustion was given as the cause in almost one-eighth of the deaths. If one notes the causes of death during the earlier years of the state hospitals, he will find that exhaustion due to mental disease was given very frequently as the cause of death, while more recently this cause is conspicuous by its absence,

TABLE II

Length of Stay of Patients 65 Years of Age and Older Prior to Death According to Age Group and Sex

	65 to 69		70 to 74		75 to 79		80 to 84		85 plus		Total		
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Total
0 to 1 mo.	81	26	103	29	125	37	93	43	64	16	466	151	617
1 to 2 mo.	27	12	44	20	25	15	24	10	13	3	133	60	193
2 to 3 mo.	13	6	21	10	23	7	24	11	11	3	92	37	129
3 to 6 mo.	32	6	35	21	35	18	23	10	14	9	139	64	203
6 to 9 mo.	26	8	31	11	22	8	22	11	11	3	112	41	153
9 to 12 mo.	17	13	23	9	17	9	6	11	8	2	71	44	115
12 to 18 mo.	20	7	22	11	24	12	11	9	15	1	92	40	132
18 to 24 mo.	21	7	18	7	19	13	10	4	10	4	78	35	113
24 to 36 mo.	16	9	29	14	15	14	10	11	7	7	77	55	132
36 to 48 mo.	19	14	14	14	13	9	6	4	6	2	58	43	101
48 to 60 mo.	21	10	19	9	14	6	7	5	0	2	61	32	93
Over	42	32	46	24	17	11	8	5	1	3	114	75	189
Total	335	150	405	179	349	159	244	134	160	55	1493	677	2170

probably due to the more efficacious use of sedation and fluids.³

DISCUSSION

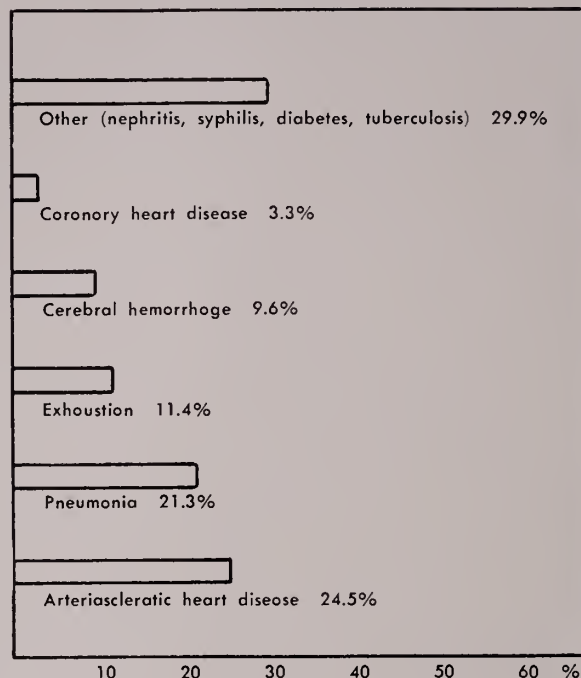
As shown in this paper, there is an ever-increasing demand for admission of elderly patients to public psychiatric hospitals and this in turn has placed a tremendous load on the hospitals and causes serious overcrowding and dangerous delay in the admission of younger psychotic patients. A large proportion of the hospital personnel and budget must necessarily be diverted to what amounts only to custodial care of the aged rather than to an active therapeutic program for younger patients who might be rehabilitated.

As far as Eastern State Hospital is concerned, within the past fifteen years the admission rate of patients 65 years of age and older has more than doubled and the rate is still going up. The increase in the admission rate of the aged has been attributed to increased longevity but the general trend of urbanization must also be considered responsible. While previously the elderly person has adjusted satisfactorily in a rural environment, now that he has been displaced into an urban environment he is unable to cope with the greater complexity of city life. The mildly confused, poorly oriented, slightly noisy and careless elderly person who can be kept useful in the household on the farm for many years is, however, impossibly inadequate as a member of a family living in a kitchenette apartment.

Another factor which should not be overlooked is the general attitude among the population that once the person becomes 65 he is entitled to social security; in other words, he becomes more or less a state charge and then it is much easier for his relatives to take the attitude, "let the state do it." Thus, arrangements are made for his commitment to a state institution for the mentally ill and the responsibility for the aged is automatically transferred to the state, especially since hospitalization in a state institution is no longer looked upon as a disgrace as it was several years ago. Finally, the facilities within the community, such as nursing homes, county farms, etc., seem to be inadequate in number to care for this type of patient.

When in the state hospital, as shown in this paper, these patients individually do not present any burden but rather collectively on the basis of their ever-increasing number of admissions. Their individual prognosis is definitely poor for very few of these patients can ever hope to be discharged and within the first twelve months almost one-half of them have died. In fact, the highest death rate occurs within the first month of admission, in spite

CHART V
Principal Causes of Death



of the fact that on admission their physical health was good and average for their ages. They are, however, called upon to make an entirely new emotional adjustment in a strange environment which at this age, because of their limited mental capacity for grasping new situations, seems almost impossible, thus setting a vicious cycle in motion by becoming more emotionally disturbed and this in turn has a detrimental, almost fatal effect on their physical health.

It is interesting to note that the average life expectancy as given by the table of the insurance commissioners⁴ for a person 65 years of age is 11.5 years, while, as shown in this paper, the average life expectancy of a person 65 years of age admitted for the first time to Eastern State Hospital or any other institution is approximately only one year or less. We are aware that we are dealing with a rather selected group of patients and that the comparison is thus somewhat unscientific. However, even with this selected group of people, one would not expect a drop from 11.5 to one year. The same holds true for the various other ages and in general the life expectancy of the aged in a state hospital is approximately less than one-tenth of that of the general population for this same age. In other words, the mortality rate is extremely high—approximately eleven times the rate expected for the corresponding age group among the general population. This in spite of the probably much better medical and nurs-

3. Perry, H. A. and Levy, S.: Intravenous Alcohol and Early Convulsive Shock in Treatment of Exhaustion Due to Mental Disorder. *J. Nerv. & Ment. Dis.*, 110:497-501, Dec., 1949.

4. 1941 Commissioners Standard Ordinary New Mortality Table issued by William A. Sullivan, State Insurance Commissioner, Olympia, Wash.

ing supervision than a person of that age could expect in his own home, or even in a nursing home or county farm.

The emotional factor of adjustment to an entirely strange and new environment seems to be the basic cause which in turn seems responsible for the high mortality rate. It is true that some of the patients do need the treatment and protection that is provided only by a hospital setting but the majority of elderly people do not seem to require hospital care and their mild degenerative changes which are characteristic of the aging process and which in turn produce slight confusion, memory defects and a slightly more exaggerated deterioration, could be very well handled within the family or some other community setting.

If this state of affairs could be corrected it would then seem to be logical that the high mortality rate among this elderly group of people could be drastically reduced and these people could live a more happy and even more useful life. However, it seems obvious that the present methods of managing the problems of the aged have proved both unsatisfactory and inadequate. The aged will not be helped in any way by being committed to the public mental institutions where they are unable to maintain dignity, self-respect and a sense of worth and usefulness. On the other hand, if this admission rate continues, and there is no reason to believe that it will not, the public mental institutions, whose primary objective is to take care of the mentally ill, will eventually become more or less custodial organizations.

There seem to be two steps, one immediate, the other long-range, which could correct this undesirable condition and which definitely would be helpful to the aged themselves. The problem as it presents itself now could be corrected as, for instance, Boyd⁵ suggests by creating a new type of institution, supported and managed by the state and providing a well-rounded and complete program of physical and psychologic care necessary for the aged. One or more such homes could be erected in an accessible rural area and should probably be of a cottage or semi-village type, minimizing physical dangers and permitting a maximum of freedom. It would differ from a county home in that it would be solely for the aged and geared to their needs. It would provide an active program of community activities and interests.

The emphasis should be upon the personal integrity of the elderly person and group activities and participation in living would be encouraged and all remaining skills and assets utilized to the fullest extent compatible with physical reserves. Every effort should be made to stimulate vocational ac-

tivities, special interests and the fullest possible enjoyment of life. There could be a cooperative working relationship with the state hospital, thus facilitating the transfer of those in whom psychoses and serious behavior disorders develop and conversely the reception of the aged hospitalized patients who have recovered from their psychotic symptoms. Such a program in the long run would represent savings to the state and community and would not only enrich the lives of the aged but also would enable the public mental hospitals to return to their primary function of treating the mentally ill.

Such a program would definitely take care of the immediate needs and problems but ultimately this problem can only be dealt with by a long-range program of education. It is not a problem of the aged but rather of the aging.^{6a,b} In the early days of medicine the responsibility of the physician was limited almost solely to the alleviation of individual suffering. It is only recently that our growing awareness has added the responsibility of preventing unnecessary disease and still more recently of building greater health for all people. For many centuries physicians were obliged by the rules of ethics and by natural diffidence to wait for people to get sick and furthermore to wait until these people were sufficiently distressed in mind and body for them to seek guidance and relief. For far too many years medical education has been predicated upon the assumption that the function of the physician was to discover, identify and treat disease. Such a limited attitude is no longer tenable and its further perpetuation can but retard the progress of both medical science and practice.

The group of the aged, therefore, certainly presents the best field wherein unnecessary disease could have been prevented and greater health built. In our opinion many of the milder forms of mental disorder, which are characteristic of the aging process, can be prevented and this with not much more than proper education. Most of the stress of later years, which in turn seems responsible for the onset of mild mental disorders, can be predicted and prevented. It is just a matter of preparing the adult for the coming senescence and to tell him what can be expected from this period of life. Since to age is to change, the aging and the aged are different persons than they were in youth. Not until this is recognized and the aged considered as not identical or even closely similar to individuals in middle life and not merely chronologically older can advances be expected.

Once pediatric medicine did realize that the child is something different than merely a little man and

5. Boyd, D. A. Jr.: Problems of Institutional Care of Aged. *Am. J. Psychiat.*, 106:616-620, Feb., 1950.

6. Stieglitz, E. J.: (a) Factors Contributing to Mental Disease in Aged. *J. of Gerontology*, 2:283-295, Oct., 1947; (b) Orientation of Geriatrics. *Geriatrics*, 4:127-135, May-June, 1949.

that infantile and juvenile nutrition, anatomy, physiology and emotional equilibrium are peculiar to the age, it made impressive and rapid advancements. Precisely similar attitudes should apply when we are dealing with the other end of life's span. If people are then prepared in this way for the aging process and some of the stresses which may occur in later years be predicted and thus prevented; if during this period they may be given new interests and values and made to be useful within their own limitations, they will be given a greater sense of security and feeling of worth. This, in our opinion, will be a long step forward to prevent the minor mental and emotional disorders characteristic of the aging process.

SUMMARY

The admission rate of aged persons, persons 65 years of age and older, to a mental hospital has increased tremendously in recent years at Eastern

State Hospital, having been more than doubled within the last fifteen years, and this trend probably will continue. It has been shown that the individual prognosis of these patients within the state hospital set-up is extremely poor and that the mortality rate is approximately eleven times greater than the rate expected for the total population during this age span.

The emotional factor of adjustment to an entirely strange and new environment seems to be the basic cause for this high mortality rate.

Two steps, one immediate and one long-range, are proposed to correct this undesirable condition. These in turn would not only be helpful to the aged themselves but in addition would represent savings to the state and community and would enable the mental hospital to return to its primary function, treatment and rehabilitation of the younger mentally ill instead of becoming a custodial organization.

Chronic Nontuberculous Psoas Abscess Due to Internal Appendiceal Stump Fistula*

H. M. BLEGEN, M.D., and JOHN H. ARMSTRONG, M.D.**

MISSOULA, MONT.

and W. J. DOYLE, M.D.

SUPERIOR, MONT.

ALTHOUGH psosas irritation from adjacent intraabdominal inflammatory disease is quite common, true nontuberculous abscess formation within the capsule of the muscle is rather rare.

The etiology and pathogenesis of this condition have been well described in the literature. Although hematogenous infections may occur, the most common origin is from infections in adjacent structures either by lymphogenous spread or direct extension. Cases have been reported following such diseases as tonsillitis, pneumonia, appendicitis, diverticulitis, proctitis, pelvic inflammatory disease, perinephric abscess and foreign bodies perforating through the bowel. When the spread is from the colon, there is usually a breakdown of the bowel wall with a direct communication between the lumen of the bowel and the abscess cavity. In most of these cases the offending organism is the *escherichia coli* bacillus.

In our search through the literature we have been unable to find a case which incriminates directly the appendiceal stump. Therefore, the following case is of sufficient interest to merit reporting.

CASE REPORT

This patient, a 46-year-old male, was admitted to

the hospital in August, 1949. He gave a history of recurring attacks of pain in the right flank and right lower abdomen which began 34 years previously after an appendectomy performed at the age of 12, presumably for acute appendicitis.

The attacks occurred once or twice a year and were of one to three weeks' duration. The pain was of a dull, aching character and tended to radiate down the right anterior thigh. During an attack, there was usually an associated low grade fever and leukocytosis. During the intervals between attacks, he was free from pain and had no complaints.

Fifteen years ago, examination elsewhere revealed a slight dilation of the right ureter, associated with microscopic blood and pus in the urine. At that time he was thought to have a stricture of the ureter and, after several cystoscopic dilations, the ureter was explored through a right flank incision. A retroperitoneal abscess was encountered in the right lateral gutter. This was drained and no further exploration made. The cause of the abscess was not determined at that time.

Following this operation he had no trouble for eight years, when in 1943 again he developed recurring attacks of pain of a similar nature. The first attack was quite severe and associated with a mild diarrhea of three weeks' duration.

Physical examination revealed a healthy, well-nourished 46-year-old male, who complained of some soreness and discomfort in the right side of the abdomen. His last attack began in July, 1949, and on admission was subsiding. He walked with a slight limp and felt more comfortable with the right thigh flexed. Abdominal examination revealed a tender mass in the right flank which followed the course of the psosas muscle.

*Read before Western Montana Medical Society, Missoula, Mont., Aug., 1949.

**From Surgical Service of Western Montana Clinic, Missoula, Mont.



Fig. A. (taken in 1943) Obscure psoas shadow on right.

Roentgen studies made in 1943 and again in 1949 showed an obscure psoas shadow on the right side. The films made in 1949 also showed hypertrophic spurs on the right margin of the second and third lumbar vertebrae at the upper pole of the mass and also an area of calcification in the lower portion of the psoas area. These latter findings were not present on the films made in 1943 (figs. A and B).

Intravenous pyelograms showed a slight dilation of the right ureter but no evidence of obstruction. Fluoroscopic examination of the colon after barium enema revealed a slight irregularity of the cecum, probably due to extrinsic pressure. Roentgenograms of the chest and spine were both negative for tuberculosis. The preoperative diagnosis was "psoas abscess, probably related to appendectomy performed 34 years previously."

Operation was performed August 13, 1949, through a right rectus incision. The cecum was plastered in the right gutter by numerous adhesions. These were separated and the right colon mobilized by incising the lateral peritoneum. Mobilization was complete except for a retroperitoneal area two centimeters in diameter in the region of the appendiceal stump where the cecum was found firmly adherent to the sheath of an enlarged, tense psoas muscle.

On separating the appendiceal stump from the capsule of the psoas muscle a fistula was demonstrated which extended from the cecum into a large abscess cavity within the psoas muscle. This abscess cavity contained degenerated, necrotic purulent material. The fistulous sinus into the cecum was excised and the bowel closed carefully with interrupted silk Halsted

sutures. The psoas abscess was then opened widely and drained externally through a right lateral stab wound.

Following surgery the patient made an uneventful recovery and to date has had no further trouble.

DISCUSSION

This case is of interest because it illustrates a chronic, recurrent, nontuberculous psoas abscess which originated from an internal appendiceal stump fistula. The symptoms began 34 years previously following appendectomy. The condition remained undiagnosed in spite of attacks of pain recurring once or twice a year. Apparently the fistula leaked at intervals, setting up an inflammatory reaction which would gradually subside until further leakage occurred. The condition finally was recognized and successfully corrected by surgical intervention.

From the location of the appendiceal stump, we assume that this patient originally had a retrocecal and retroperitoneal appendix and that at some time following surgery the stump broke down with resultant abscess formation in the psoas muscle. The case illustrates the importance of careful, secure closure of the appendiceal stump and suggests that in the retroperitoneal area, especially, inversion, rather than simple ligation, should be performed.

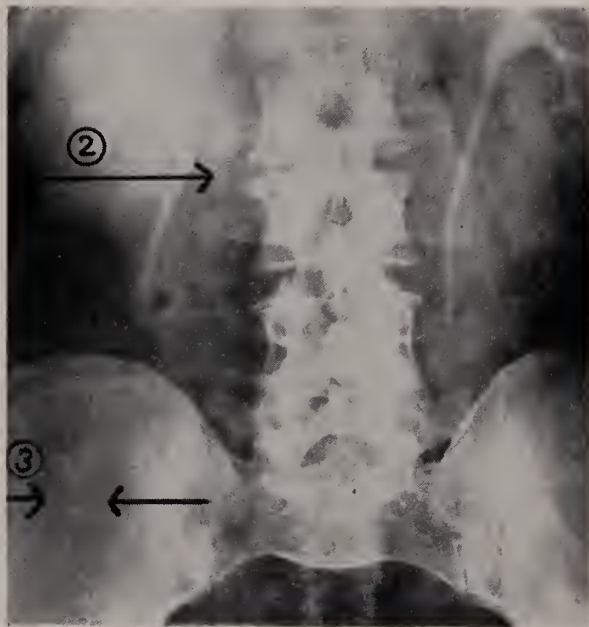
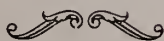


Fig. B. (taken in 1949) 1. Obscure psoas shadow on right. 2. Calcification in lower portion of psoas mass. 3. Spur formation at second and third lumbar vertebra at upper pole of the psoas mass. The bodies of the vertebrae show no signs of tuberculosis.



Critical Analysis of Recent Advances in Gynecology*

RICHARD D. REEKIE, M.D.

SPOKANE, WASH.

THIS is a paper discussing the more recent advances in gynecology, covering the era from completion of my hospital residency thirteen years ago to the present time. So many advances have occurred that available space is inadequate to do the subject justice. Discussion, therefore, will cover only those points which seem of most value. The subject is divided into more or less diagnostic aids, therapeutic aids, menstrual and hormonal aberrations, sterility, infection, neoplasia and surgery.

Many phases of advance were first being introduced during the time I was a student and in residency. For example, under diagnostic aids the smear or cytologic examination was being used by laboratory workers and some few articles had occurred in the literature by Shorr, Papannicalaou and others who were at that time using the smear for hormonal qualitative assay studies. The endometrial biopsy had just begun to be used for hormonal evaluation in menstrual aberrations. The basal body temperature curve was unsuspected and has actually come into wide use in the last three to four years. Decker had just introduced his culdoscope and was advocating culdoscopy. I actually saw two peritoneoscopies during training but it had not achieved wide use. Many hormonal assays now available were unknown or just beginning to be used in the mid-thirties.

In the field of therapeutic aids, chemotherapy and antibiotics have been completely developed since that time. We had prontosil and neoprontosil and thought we were very fortunate. The perineometer of Kagele was unheard of and the hormonology of today is a far cry from the rather crude and relatively weak hormones available in the early and mid-thirties. The change in gynecologic hormonology from hypodermic injections to an almost exclusive oral administration has taken place in the last five to six years. One must also mention the evolution in pre- and postoperative care since the prewar era.

There are a great many things that could be discussed under the heading of menstrual and hormonal aberrations. Just a few words about a few of the major problems. Premenstrual tension and dysmenorrhea are frequently associated and as such can be discussed simultaneously. Psychosomatic approach to this problem is probably more important than in any other phase of gynecology. But one must not overlook possible organic pathology. Exercise, sedation, antispasmodics, analgesics, all have a role. In premenstrual tension, especially with dys-

menorrhea, the problem is often one of relative hyperestrinism, yet actual estrin deficiency. Many have symptoms simulating the menopause, in which there is relative deficiency or complete lack of progesterone. Psychosomatic, socioeconomic and psychosexual problems must be discovered and corrected. In treatment of the condition, dehydration constitutes a relatively new therapy. It has been shown that there is premenstrual edema of all tissues, particularly of the cerebrum due to hormonal imbalance, and that dehydration is often of help in treatment. Limitation of salt and fluid intake, correction of constipation and administration of dehydrating agents such as ammonium chloride, plus progestogens or androgens are the most effective routine.

Treatment of the menopause is fundamentally the same as it was fifteen years ago. Explanation of the normal transition, reassurance, supervision, improvement of general health, use of mild sedation and, probably a new addition, use of the tocopherols in fairly large doses will suffice in a large percentage of patients. As far as hormones are concerned, the same admonitions are still valid. Patients are aware of the dangers of carcinogenesis from estrogens, far in excess of their probable carcinogenic danger and considerable hysteria has been developed by the lay press. A comparatively new addition to treatment of the menopause is the use of testosterone. Many patients are very comfortable on small doses of testosterone, without abnormal bleeding or dangers of carcinogenesis.

A newer thought in hormone therapy of the menopausal patient is use of triple steroids, that is, combinations of estrogens, androgens and progestogens on a cyclic basis simulating the normal hormonal balance of the actively menstruating patient, with the idea of gradually weaning her. The newest addition to hormone therapy has been the complete elimination of hypodermic steroids and utilization of satisfactory active oral preparations, either for ingestion or for sublingual or buccal administration. Local application of estrogens to the vagina in the form of suppositories, creams, etc., has proven quite satisfactory in treating many local conditions as well as occasional cases of stress incontinence.

Treatment of abortion has been improved a great deal in the past fifteen years, particularly with the recent knowledge that stilbestrol is a progestin stimulant and also a "vascular" hormone, increasing the caliber of the vessels of the uterus and improving the circulation. Many patients who habitually abort or threaten abortion now have salvage

*Read at Twelfth Annual Meeting Spokane Surgical Society, Spokane, Wash., April 6, 1950.

of their pregnancies by the use of large doses of stilbestrol.

In the field of sterility, probably the greatest gynecologic advancements have been made. Meeker published his first book on sterility about the time I was a senior student. There have been a great many additions to this literature since that time. There are so many things that could be discussed under this heading that one hesitates even to start. In any discussion of sterility it should be emphasized that the male constitutes one-third of the problem. The male factor should be studied first. One of the hardest things is to convince the husband that mechanical potency is *not* synonymous with generative potency.

Many things have been added to the treatment of the female factor in sterility. The basal body temperature has proven a great aid in studying the female factor. By its use one can usually tell whether or not the patient ovulates, if so, when she ovulates and how complete or incomplete, satisfactory or unsatisfactory is the progestational phase of her ovarian function. The endometrial biopsy which was introduced as a hormonal diagnostic aid about the time of my residency by Emil Novak and others has proven of extreme value in judging the potency of the ovary both in the proliferative and the progestational phases of function. Endometrial biopsies performed at the onset of menstruation are office procedures which can be done by any doctor. Their interpretation, however, should be left to one with experience in the study of pathologic and cytologic specimens. Tests for tubal patency were introduced by Rubin a number of years ago. They should be performed only in the immediate post-menstrual phase. They are not only diagnostic but often therapeutic. Use of air or gas is less therapeutic than oil. There are many media used now, each having its special value. The more viscid media has greatest therapeutic effect but is harder to use.

Tubal plastic operations are little more successful today than they were fifteen or twenty years ago. The addition of chemo- and antibiotic therapy has increased salvage a little in these patients. Expert surgeons are reporting only slightly greater success with these operations than they did fifteen years ago. The locale of the obstruction is the determining factor. Interstitial occlusion is not amenable to surgery, only the ampullary operations have value. The functional residual one gets after plastic tubal operations is so unsatisfactory, often leading to tubal pregnancy, etc., that, in spite of the use of chemotherapy, antibiotics and repeated oil or gas insufflation, these patients have little success in achieving pregnancy. It is the consensus of opinion of most authorities that the end results do not justify the risk of surgery.

Polycystic ovaries are probably the victims of

more unnecessary, undesirable surgery than any part of the female generative tract. Ultraconservatism is advised in handling these organs. The use of repeated small doses of roentgen therapy or large doses of stilbestrol for inhibition of the ovulatory mechanisms should be tried. If one is unsuccessful with the use of these modalities, wedge resection of the ovary, by the method of Stein, rather than complete removal of the organ, particularly if the patient is in the sterility group, is the operation of choice.

Endometriosis is on the increase. There is no obvious explanation for this fact. A report on endometriosis from Boston, in the early part of this century, indicated 6 to 7 per cent of surgical patients with endometriosis. Meigs recently made the statement at a meeting in Los Angeles that 25 per cent of all pelvic surgery in his institution had some associated endometriosis. Treatment of endometriosis is swinging away from the total extirpation of the pelvic organs to an attitude of conservatism. In fact, in many quarters, nonsurgical treatment is being used with success. I refer to the inhibition of the ovulatory mechanism by the use of large doses of stilbestrol. Karl Karnaky of Houston, Texas, has been a pioneer in this field. Still newer additions to our therapy of endometriosis have been the use of androgens. A number of men throughout the country have used androgens in controlled series of cases with encouraging results. Surgery should be as conservative as possible, especially in the younger group of women, and it should be recognized by all who do pelvic surgery that not all chocolate cysts are endometrial in origin.

In the field of pelvic infection, much has transpired. I well remember our chronic P.I.D. ward. We never had less than twelve to fifteen patients with a chronic pelvic inflammatory disease who spent weeks and often months under unsuccessful treatment. Many of them, in fact, probably most of them, ultimately wound up on the operating table. With the addition of sulpha drugs and antibiotics and the knowledge on the part of the patient generated by the Armed Services, that these drugs are therapeutic and prophylactic, especially when used early, many of these chronics are now avoided. Treatment with antibiotics has recently become extremely complex. A few years ago, with only a few special agents, it was rather simple, but now, with a number of weapons, one must know the proper antibiotic or chemotherapeutic agent or best combination to treat the particular organism involved in the pelvic inflammation. For example, in treating gram positive cocci, a combination of penicillin, streptomycin and chloromycetin has been recommended, while, in treating gram negative cocci, streptomycin, aureomycin or chloromycetin seem to be the best combination.

The pelvic tuberculosis patient now may have

greater expectation of cure than previously. Dihydrostreptomycin orally, pre- and postoperatively and in saline solution intraperitoneally at surgery has improved the end results. Gonorrhea is treated effectively and prophylactically with penicillin or sulpha drugs or both. Lymphogranulomatous diseases are treated effectively with aureomycin and streptomycin. And so on down the list. The literature is replete with numerous recent summaries of this phase of gynecology.

In the field of neoplasia probably not so much advance has taken place in the last fifteen years. Treatment of lesions of the vulva require considerable care and tact. One must remember that pruritis vulvae is fully 75 per cent neurogenic. The application of chemicals, x-ray, etc., to these patients often makes a bad situation worse. The atrophic group with kraurosis and leukoplakia constitutes about 15 per cent of cases and the other 10 per cent are on a systemic basis, i.e., diabetes, allergy, hormonal, etc., often leading to trichomoniasis or fungal infections. Treatment is frequently ineffectual. These patients are notoriously medical shoppers.

Benign lesions of the vulva, beyond medical treatment, are best treated by simple vulvectomy. Malignant tumors of the vulva are best treated by radical vulvectomy with inguinal gland resection. X-ray offers little help; in fact, most roentgenologists will not treat lesions of the vulva. All lesions of the cervix constitute major problems. With the advent of smear technics large series of patients may be screened readily. The smear should never be considered as a final diagnostic procedure. It is simply a laboratory aid in our diagnosis. Biopsy is still a more reliable procedure but one must emphasize the necessity of multiple biopsies or conization. Obviously, even with extremely carefully performed biopsy, one may miss cancer. The smear and the biopsy are only as reliable as the ability of the person interpreting them. There are few people well enough trained to diagnose cancer by smear alone and, if the smear forms the sole basis for a diagnosis of cancer, many women are going to sacrifice their uteri to a misinterpreted vaginal smear. This statement does not nullify the value of the smear but one must attach great importance to the ability of the person interpreting these procedures.

Treatment of cancer of the cervix has not changed much in the last fifteen years. Probably a turn toward surgery is the most important aspect of this phase of our subject. Many good surgeons, notably among them Meigs, prefer surgery with total extirpation of the uterus, tubes, ovaries and regional lymph nodes for the preinvasive type of cancer. They also advise surgery in the stage I and favorable stage II types of cancer. In classifying cancer of the cervix it is best to do so on a clinical rather

than an histologic basis. Experience teaches that histology of the cancer has very little value when planning treatment. In advanced cases irradiation is still the procedure of choice. However, Meigs, in a very select group of patients, i.e., the healthy, thin, and easily accessible individual, does radical surgery. In Meigs' hands this may be satisfactory, but it is formidable surgery. Adenocarcinoma of the cervix is a surgical disease.

Treatment of lesions of the corpus, notably fibroids, has been controversial for years and I do not believe there has been much change in the attitude toward these tumors except that most men decry the pernicious removal of tiny fibroids of the uterus. As one of the foremost educators in this field has recently stated, "it is one of the greatest surgical rackets in modern medicine." Treatment of carcinoma of the body of the uterus is most often irradiation followed in a period of time, usually about six weeks, with total removal of the uterus, tubes and ovaries.

Carcinoma of the tube is a postoperative diagnosis. One must use judgment in treating tumors of the ovary. Treatment of polycystic ovaries has already been discussed. Deciding whether a tumor of the ovary is benign or not often takes a great deal of judgment. One can arrive at some conclusions on the basis of the size of the tumor, its consistency, the type of dysfunction produced. Very few lesions of the ovary are surgical emergencies. Functional tumors of the ovary, i.e., granulosa cell tumor, arrhenoblastoma, Brenner's tumors, etc., have been clarified rather recently. They have a rather high malignancy rating. Diagnosis of malignancy of the ovary is a difficult preoperative diagnosis. Generalizations can be made but it must be emphasized that they are only generalizations. Any tumor as large as a tennis ball or larger is a surgical tumor. Tumors under that size may be safely observed. In the menopausal or postmenopausal age group, one should consider all fairly large tumors of the ovary as malignant. Treatment is surgical. Irradiation has much less value than it has in carcinoma of the uterus. One must sound a warning not to use estrogens for patients in this age group who have tumors of the pelvis.

In discussing tumors of the breast it becomes very difficult to condense one's statements. If the tumors are diffuse, adenosis throughout the breast, the chance of malignancy is not great. This is not chronic cystic mastitis found in localized areas of the breast. Any solitary cyst or localized mass of cysts is a surgical condition. Treatment of malignancy of the breast is still a surgical procedure. Radical mastectomy is the operation of choice. One should not limit his criteria for operability too sharply or some patients may be denied a cure by complete removal. Irradiation is adjunctive treat-

ment. Use of steroid hormones is empiric in spite of the numerous recent articles published concerning this type of treatment. Estrogens should never be used in treating breast cancer in any patient who is not at least five years postmenopausal.

In the older age group, estrogens are of very distinct value in that they lead to subjective and physical improvement with regression of metastases and the healing of ulcers. The use of androgens in treatment of cancer of the breast has no relation to the menstrual age or the age of onset of the cancer. Use of steroids produces symptomatic improvement only. There is progression of the disease and most patients die of cancer. However, their last few months are made much more comfortable. Progesterone has recently been suggested in the treatment of carcinoma of the breast. It has been used in addition to the estrogens in the elderly group and in addition to androgens in the younger group.

In the field of gynecologic surgery, probably the most important improvements that have occurred in the last fifteen years are in preoperative and postoperative care. In preoperative treatment, much has been added to our knowledge of the vaginal flora and chemistry by investigations of such men as Hesseltine, Karnaky and Dieckman, to mention just three. Where vaginal surgery is anticipated, the proper preparation of the vagina for this surgery by the use of hormones, chemical substances, primarily of an acid pH and the proper rehabilitation of the vagina to a relatively normal condition before surgery is done has helped to increase the success of surgery. Few changes in operative technic have been introduced.

Treatment of urinary incontinence has been aided in the development by Kagele of the perineometer. Exercise of the perineal muscles by this mechanism has cured a great many patients who otherwise would have gone to major surgery, oftentimes with lack of success. It is a procedure and an instrument which bears investigation by anybody doing pelvic and particularly vaginal surgery. Estrogens often prove effective in lessening urinary incontinence in older women.

A diagnostic aid to the gynecological surgeon is Decker's culdoscope, an instrument introduced into the cul-de-sac via the vaginal vault for direct pelvic visualization. It is not a recommended office procedure, but is more applicable to hospital practice.

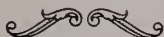
It requires considerable experience to develop technic and diagnostic acumen. Dangers in its use are perforation of the bowel or the uterus, in the retroversion group, rupturing of pelvic abscesses, endometrial cysts, etc. There is some danger, in the cardiac case, of heart failure when the inrush of air allows the viscera to gravitate precipitously against the diaphragm with the patient in the knee-chest position, which position is used for its introduction. Some feel the information gained does not justify the risk and that most of the time exploratory laparotomy is the procedure of choice.

The same thing may be said about the peritoneoscopy. Peritoneoscopy for pelvic lesions has some value and yet its risks are rather great in the patients that have enough pelvic pathology to indicate its use, just as in the use of the culdoscope. Probably a small exploratory laparotomy has no more risk or longer convalescence than either of the other procedures.

The old argument, total versus subtotal hysterectomy, is still going on. We are no closer to a settlement of this argument today than we were fifteen years ago. In postoperative care, early ambulation and early feeding are distinct advances. Recent additions to postoperative local therapy following vaginal surgery are the various creams and jellies that are available such as *aci-jel*, *propion-jell*, sulpha creams, estrogen preparations, etc., which inhibit infections and putrefaction and speed healing.

A last point, worthy of mention, is a newer concept of the question of whether or not to remove the uterus when both tubes are removed. There are two schools of thought; one is that the uterus has some hormonal influence and therefore should be conserved. A newer and more practical viewpoint is that the uterus is of no value except for child-bearing, and therefore, whenever the connection between ovary and uterus is severed, it is practical to remove the uterus. Thus, the patient becomes more amenable to hormone therapy later and avoids difficulty of aberrant bleeding later. Whether you are of this latter opinion depends on your experience with these patients during the climacteric.

In closing, it is admitted that the subject has been very sketchily and imperfectly covered, but I hope I have been of some aid in your inventory of your gynecologic armamentarium.



The Care and Healing of Traumatic Wounds*

JAMES G. MATTHEWS, M.D.

SPOKANE, WASH.

OVER three thousand years ago a wound was defined as "a solution of the continuity of tissue" and this answer has withstood all attacks since that time. The process of wound healing dates back to the earliest concept of surgery and in recent years has undergone considerable investigation and research, causing many changes in our technics of years ago.

The external violence that produces these wounds differs greatly but in our civilian life we are mostly concerned with automobile crashes and gunshot wounds. Both types tend to carry fragments of one's clothes and other foreign material into the deep tissues of the body and with these many different types of bacteria. Therefore, all traumatic wounds must be infected to a greater or lesser degree and our every effort should be made to prevent the much-feared secondary infection.

The type of organism carried into a wound varies. Much depends upon the section of the country and the location of the same area. As an illustration, during the Second World War there was little or no gas bacillus infection with the wounds of the North African campaign, that country being mostly desert and very sparsely inhabited. But, in contrast, in the Italian campaign, where the country has been thickly inhabited for many centuries and the soil badly contaminated, practically all wounds became infected with the gas bacillus.

The woodsmen of the Northwest boast they never get infections in their open wounds when they are working in the forest. "We smear a little balsam on the cut and wrap it up." This illustration teaches us a very definite lesson—the more thickly inhabited an area, the more liable we are to get infections.

The first care of a traumatic wound is most important and the following is a good rule to observe:

1. Cover the wound with a sterile dressing.
2. Bandage firmly so no peeping Tom can raise up the dressing "just to see what the wound looks like." This may save you a secondary infection.
3. Control hemorrhage by pressure or a tourniquet.
4. Conserve body heat.
5. Sedation for pain.
6. Splint extremities if involved.
7. Move to hospital.
8. Replace body fluids by blood transfusion, plasma or glucose.
9. Three or four hundred thousand units of penicillin. Repeat every eight hours.

10. Prophylactic injection of gas and tetanus serum.

After these things are accomplished and you feel your patient's condition is good enough for debridement, do not proceed until you have made sure the hemoglobin, hematocrit and plasma proteid levels are correct. A general anesthetic, as a rule, is essential, unless you do not have to do a debridement. Then the local infiltration of the tissues with 1 per cent novocaine solution will suffice. Cleanse thoroughly, especially if on the face. Get every speck of foreign material out of the tissues. If you do not, you will have blue spots in your scar and they will be a walking example of poor technic for the rest of your life. Primary suturing is indicated in these cases. You practically never do a debridement of a wound of the face. With thorough cleansing and with the splendid blood supply of the tissues one usually gets primary union. This is also applicable to the scalp and hands.

I feel a sterile gloved hand should hold sterile dressings in the wound while the area is being thoroughly cleansed with a soft bristle brush. Then remove the dressing and with soap and water scrub the wound well and follow with a copious amount of normal salt solution. This does more toward getting rid of the foreign material that may have been carried in the wound than any other method.

The Kelly pad is the ideal thing to catch and carry off the water but, alas, that old faithful friend has lost its prestige and is seldom found in our modern surgeries.

I feel the local use of antiseptics in the traumatic wound is of little value. If they are strong enough to kill all the bacteria, they also destroy human tissues. In so doing you have a wonderful haven in which the bacteria can multiply. I may be old-fashioned but I don't want you to think I disapprove of local antiseptics for I use them routinely, but do not have the confidence in them that I do in the thorough scrubbing of an open wound.

Now proceed with your debridement, using the best surgical technic and judgment at your command, thus avoiding as far as possible the unnecessary secondary infection that can so easily be carried into this type of wound.

The skin should be cut longitudinally and sufficient length to thoroughly explore the deepest recesses of the wound, carefully removing all pieces of cloth or other foreign substance.

If a comminuted fracture is present, remove the small fragments of loose bone. The more thorough your debridement, the more complete is the eradica-

*Read at Twelfth Annual Meeting Spokane Surgical Society, Spokane, Wash., April 8, 1950.

tion of infection. Remove all devitalized tissue and in some cases a whole muscle or more may have to be sacrificed. Always use the utmost care not to injure the nerves or blood vessels.

Only the ragged edges of the skin should be removed, for the skin has a greater resistance to infection than the other tissues, so please do not sacrifice it by unnecessarily wide dissection. Perfect control of hemorrhage is essential.

I do not believe any wound needing extensive debridement should be subjected to a primary closure but wait four or five days and do a delayed closure, when the tissues have built up their maximum resistance.

I will say nothing about secondary suturing of a wound, for I feel that it is brought about only by faulty technic or poor surgical judgment in the early care of a wound.

If your wound is extensive and deep, I believe in placing a catheter in the bottom of the wound, with strips of vaseline gauze lining the wound. Fill in the wound with loose gauze dressings and top off with waste cotton. Then apply firmly an elastic bandage. The limb should be splinted and, if a cast is applied, it should be bivalved and the limb elevated.

There should be injected into the catheter 200,000 units of penicillin in 5 or 10 cc. of H₂O every eight hours for three days. Then do your delayed suturing, for by this time the tissues have reached their maximum resistance and they are still soft and pliable, the skin edges have not turned in and sealed down by epithelial proliferation, thus doing away with undercutting of the skin.

There should be as little tension as possible on your sutures, for too much will spell defeat of your purpose. If you delay your suturing too long, the tissues become set and delayed suturing becomes much more difficult.

Routine bacterial count of the flora of the wound has been given up to a large degree. The intelligent and energetic use of chemotherapy and antibiotics, both local and systemic, has greatly increased the immunity of the tissues, also destroying most of the bacteria in the wound. On the fourth or fifth day you can do your delayed suturing, for the tissue resistance will destroy the few bacteria that may be lurking around the wound.

Firm bandaging and immobilization of a wound accomplishes five important things: (1) keeps down edema of the wound, (2) eliminates dead spaces, (3) controls oozing, (4) reduces venous stasis, (5) reduces the amount of plastic substance forming in the wound which means less scars.

Wound healing is divided into two definite periods: (1) the period of lag which is the first three or four days following injury, when the tissue is building up its immunity (2) the period of fibroplasia which forms the framework of the scar and,

if after the continuity of the skin is attained the fibroblasts continue to grow, we will get a keloid.

Extensive research work by Ravdin and Frank have shown conclusively that cellular repair and regeneration of tissue require proteids and without amino-acid growth will not take place. Working on hypoproteinemic animals they found 72 per cent of wounds failed to heal or disrupted, showing conclusively the necessity of proteids in wound healing.

Berman and his associates have shown "there is little or no local immunity in a wound until after twenty-four hours and the maximum reached in four days."

Copper showed in the last world war that wounds of the thigh that were not cared for by delayed suturing were off average over 100 days and only 54 per cent were able to return to the line. But, where delayed suturing was instituted, the average time off was 88 days and 90 per cent went back to the lines.

Clark has shown that diet plays a most important part in wound healing: (1) high fat diet—healing commences in six days, (2) mixed diet—healing commences in four days, (3) high carbohydrate diet—healing commences in three days, (4) high proteid diet—healing commences on first day.

Lowry and Curtis report over 700 cases where debridement was performed; on 4th or 5th day delayed suturing was done and their success was above 90 per cent. These from their experience in the second world war and it is fair to assume that, if these cases had been in civilian life, their results would have been over 98 per cent.

The popularity of delayed suturing of wounds has spread to other fields than traumatic wounds. There are most favorable reports in pilonidal cysts and diffuse peritonitis cases. McLaughlin has demonstrated quite conclusively that there is a great advantage in delayed suturing of a stump, following amputation for gangrene.

The use of bacitracin has produced some splendid results in badly infected wounds; use 1000 units of bacitracin in 1 cc. H₂O and mix with 1 cc. 2 per cent novocaine and inject in the tissues around the wound. Then supplement it with topical application of loose gauze saturated with bacitracin. Keep saturated every six hours and the wound will be clinically ready for delayed suturing in three to five days.

Continuous use of wet, hot packs has been shown to be quite a detriment to wound healing and adds greatly to the danger of secondary infection. Only in very gross infection should hot dressings be used and then for only 24 to 48 hours.

Lower and Curtis report 20 per cent better results from wounds not having been treated by hot dressings prior to debridement. This is quite different from our early teaching and completely reverses the

regulations laid down by Poole during the first world war.

It might be opportune for me to mention here the use of chlorophyll which does so much in the stimulation of epithelial growth, used in the form of chloresium (the trade name) Rystan Co., Mt. Vernon, N. Y. This is useful when skin grafts have been removed and is especially indicated in hand injuries where there has been a great deal of skin loss from the fingers. The use of chloresium once or twice a day will save you many skin grafts, also greatly reduce the cost of the care of your patient, and we should all be more concerned about the costs than we have been in the past. This thought is directed more to the younger men who so often throw the pharmacopeia at a patient or keep him in the hospital an unnecessarily long time because it is a bureau or state case.

CONCLUSION

1. Protect the wound against secondary infections.
2. Control hemorrhage by pressure rather than tourniquet.

3. Preserve body heat and alleviate pain.
4. Firm bandaging and splinting of extremities.
5. Replace body fluids.
6. Avoid use of hot dressings except in gross infections.
7. Do not do a mutilating debridement. Conserve as much skin as possible.
8. Delayed suturing of wounds is one of the recent great advancements in surgery. It greatly reduces hospital confinement and produces the minimum amount of scar.
9. Do everything in your power to help build up your patient's tissue resistance.
10. Bear in mind that your tissue immunity is nil for the first 24 hours and gradually builds up for four or five days and the fourth day after debridement is accepted as the ideal time for delayed suturing.
11. There are many things that can be done to stimulate wound healing but nothing supplants good sound surgical judgment or rigid technic.

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Policy Long Overdue

By its action before adjournment, the midyear session of the House of Delegates took a step which had long been talked of but about which nothing had previously been done. By action of the House, it will no longer be possible for a request for approval of some organization to be acted upon at the time it is first submitted. Instead, the House of Delegates instructed that the mandatory procedure will be to refer the request to a committee for study, following the report of which the request will be considered by either the House of Delegates or the Council as the case may be.

It is anticipated this procedure will actually expedite requests for approval in that it will avoid the confusion and lengthy explanations and debate which

so often were required in the past when a request for approval was the first the Council or Delegates heard of the matter. Now the request and all accompanying data can be studied in advance by the screening committee, and a recommendation submitted. This should shorten debate and result in a quicker disposal of the request.

Missing in the discussion of requests for approval was the point frequently mentioned that any and all approval given be for one year only, expiring at either the calendar year-end, or at the time of the Oregon State Medical Society annual meeting. Possibly some action to include this suggestion may be taken at a subsequent date.

The Lessons of Senate Bill 376

The checkered course of Senate Bill 376, as it made its perilous way among the legislative rocks and rapids of Oregon's longest law-making session, holds a number of truths—and lessons—for the medical profession of Oregon which, if well noted, could advantageously be used in the future.

Once again was demonstrated the truth that laws do not just happen. Even if a bill is clearly in the

public interest this fact carries little or no weight with legislators, many of whom are too wrapped up in their own immediate affairs to bother in the slightest about an indefinite, hard to define "public" which is not vocal. And even if a bill is designed merely to correct an oversight or defect in the work of a previous legislature, current legislators are not the least im-

pressed with the necessity of doing anything about it, glaring though the defect may be.

To come to the attention of a legislature what legislation needs is not merit—although that helps—but simply a good, persistent sponsor backed by an adequate public, the more vocal and communicative the better.

S. B. 376 had its origin in one of those legal voids which can be anticipated in any legislative process, but which many laymen feel happens because legislatures are composed largely of lawyers and lawyers need to keep busy. When the hospital district law was passed the legislators probably thought it was a good bill, giving ample authority to the hospital district governing board in each district to run the affairs of the hospital. In order to do this, as previously pointed out in these columns, a provision of the original bill permitting osteopaths to practice in such hospitals was stricken, and the bill passed without reference to them or any other cults.

Into this situation came the attorney general's department, also as previously related and as will be commented upon later in this report, with a ruling to the effect any practitioners of the healing arts licensed by the state of Oregon could not be excluded from such hospitals built with tax money.

In view of the dropping of the osteopathic provision from the original draft, it was then, and still is, difficult for many doctors familiar with the composition and operation of the attorney general's department to believe this ruling was other than political, since it ran counter to long-established and proven public interest.

It is a matter of record the lack of public protection inherent in the ruling was called to the attention of the attorney general's department. It is true the ruling was modified slightly after these representations, but not to the extent or in a manner to assure adequate protection of the public. It therefore became obvious any safeguarding of the public interest would have to be done by forces beyond the confines of the state department of justice. To remedy the defect or oversight in the law, which afforded the justice department the opportunity for its strange, not-in-the-public-interest ruling, a bill to amend the hospital district law would be necessary. Accordingly Senate Bill 299 was drafted.

The story of the difficult birth of S. B. 299 is interesting in its own right, but too involved to bear relating here. It should be stated for the record, however, that the committee of the senate dealing with health matters, which might logically be supposed to be interested in the topic, wished to have no part of the bill, requesting "since it was a legal matter" the bill should go to the committee on laws, a line of reasoning which would automatically channel all legislation to the committee on laws. Eventually, S. B. 299 was dropped into the hopper as a "committee" bill by the Committee on Public Health—but promptly referred to the committee on laws!

The bill languished for three weeks in the laws committee. Then one day it bounced back to the floor of the senate, and by a two-vote margin was referred to the Committee on Public Health which had intro-

duced it—with several members of that committee arguing and voting against its referral to themselves!

This committee promptly announced it would hold the usual hearings on the bill, with thirty minutes allotted to proponents and opponents. Some members of the committee privately informed some proponents the members could guarantee it would not be brought to the floor of the senate for a vote unless there was absolute assurance, on their own polling, of an overwhelmingly favorable vote for the bill. Since members of the senate who might be supposed to be interested in the bill declined to work for its passage, this clearly put the matter of an educational campaign directly up to those favoring the legislation, chiefly the citizens and members of governing boards of the areas in the state affected by the hospital district law, and by the medical profession throughout the state.

While this intensive effort to acquaint the senators with the merits of the legislation was in progress, the consideration of S. B. 299 by the public health committee took another of its strange turns. S. B. 299 was dropped. But in its stead came a substitute bill, S. B. 376, and the agreement to report S. B. 376 to the senate floor with a "do pass" recommendation.

Thanks to the intensive efforts put forth by many individual doctors throughout the state, as well as lay citizens interested in this hospital district law amendment, the vast majority of senators had enough information on the bill that there was only modest debate before the bill was passed *with only four dissenting votes*.

Voting against the measure were Senator Vernon Bull of LaGrande, Senator Sam Coon of Keating, Senator Truman A. Chase of Eugene and Senator Marie Wilcox of Grants Pass. It is interesting to note that Senators Bull and Chase were members of the senate committee on public health, which originally sponsored the legislation.

On the house side of the legislature the bill was referred to the committee on medicine by Dr. Dammasch of Portland and was brought to a hearing similar to that held on the senate side. It was sent to the floor of the house with a "do pass" report, and in the ensuing vote was passed with but *two* negative votes.

Those representatives voting against the bill were G. D. Gleason of Portland and Robt. R. Klemesen of St. Helens.

A few days after passage S. B. 376 received Governor McKay's signature, with the result that as the hospital district law now stands the governing board of such hospitals has the legal power to operate them in the public interest regardless of their tax money origin.

In retrospect it appears most if not all of the expense and trouble occasioned by the introduction of S. B. 376 and its predecessor—including this contribution to the prolongation and taxpayer cost of Oregon's longest legislative session—could have been avoided if, in the original ruling, the attorney general's department had taken into consideration the well-being of all our citizens.

Under this demonstrated strange inability to distinguish political pressure from the best interests of

the people generally, or which is equally serious, the inability to distinguish between good and bad advice, one wonders if the present incumbent responsible for

the conduct of the attorney general's office might not be much happier retired to the private practice of law should he seek a return to the office at 1952 elections.

Advance News on State Convention

Although the state convention is still three months in the offing (October 10-13), plans are already formulated and well on their way to completion. The convention will feature an outstanding program of lectures and panel discussions by internationally known guest speakers of the 14th Sommer Memorial Lectures and University of Oregon Medical School faculty members. Lectures will be held in the Commandery Room of the Masonic Temple in Portland.

This year's convention will also feature one of the largest technical exhibits ever displayed at an annual session. Scientific exhibits will be held in the Sunken Ballroom of the Masonic Temple, where space has been provided for 44 exhibits.

After business, of course, comes pleasure. The session will close with the football game between the University of Oregon and the University of Washington, followed by the annual banquet and dance.

Clark Report Makes Bow

The report on Voluntary Health Insurance plans prepared by Dr. Dean Clark's group, on instructions from and on behalf of the Health Subcommittee of the Senate Labor and Public Welfare Committee, has been released.

When it was announced by the Senate Subcommittee several months ago such a report would be undertaken, and Dr. Dean Clark was named to head the study committee making the investigation, many doctors felt it was a foregone conclusion the findings and wording of the report would be such that the exponents of socialized medicine could refer to the report to support their efforts and intentions.

Those holding this opinion will be inclined to feel it is supported by the pains taken by the senate subcommittee to emphasize that the findings and recommendations "are not those of the committee or its individual members" but of Dr. Clark and his group. They visualize this disclaimer as preparing the way for the committee to make frequent referral to the report to justify the probable activities along so-called health lines of the Labor and Public Welfare Committee.

The report (advance copies of which were furnished to those attending the Blue Shield plans conference last April) consists of seven chapters devoted to: (1) methods of study and sources of information, (2) numbers of persons having insurance, (3) benefits, (4) insurance costs, (5) medical costs and insur-

ance protection, (6) medical care insurance and the industrial, rural and aged populations, and (7) the role of medical care insurance.

The report admits the prepaid medical care movement is the most dynamic thing to hit the health field in recent decades, and discloses that in 1949 the total expenditures for health services reached close to 11 billion dollars, of which ten billion went for medical care and over one billion for public health, research and education. It states that 50 per cent of the population has some form of insurance or protection against part of the cost of medical care. Broken down, this shows 15 per cent having hospital protection only, 21 per cent with some protection against hospital and surgical costs, 11 per cent with hospital, surgical and some medical coverage, and 3 per cent with comprehensive medical care coverage.

The report professes to see a continued rapid growth for voluntary health insurance "for those who can be reached," but claims there is room for "substantial further broadening of . . . preventive medicine and health education . . . for providing care in an organized fashion, for creation of facilities and for attracting physicians and others to areas where they are now deficient."

A third section of the report, dealing with state and local health services, will be issued later.

A few copies of the entire report to date can be obtained free by writing to the Senate Labor and Public Welfare Committee (of which Senator Wayne Morse is a member).

O. M. W.

Children's Bureau Studying New E.M.I.C. Possibility

Doctors who are aware of the current studies being carried out by the Children's Bureau of the Federal Security Administration relative to a possible renewal of some sort of E.M.I.C. program, might like to have some idea of what this Bureau is and how it operates.

A special bulletin from the A. M. A. Washington office gives this data. Started in 1912 with a budget of \$25,640, all for administration, and 15 people. Now employs 260 people to handle \$32,000,000! Seventeen of these are physicians.

Bureau operates with a chief's office (Miss Katharine F. Lenroot, 12 employees and \$85,223) and six divisions, as follows:

Division of Research—Edward E. Schwartz, 46 employees, \$239,022.

Division of Reports—Mary Taylor, 23 people, and \$247,826.

Division of Health Services—Dr. Arthur J. Lesser, 80 persons, a budget of \$494,058 for office and \$24,339,-804 for grants in aid.

Division of Social Services—Mildred M. Arnold, 49 employees, \$287,573 for office and \$8,988,920 for grants.

Division of International Cooperation—(Point IV program)—Miss Mary Larabee, 9 people, budget of \$71,700 transferred from State Department.

Division of Administrative Services—Laura E. Warren, 42 people and \$146,298.

Pete the Pest Says

How to Win a Vote: Members of state legislature are immune from arrest while attending, going to and from, legislative sessions, have some other privileges not accorded the citizens who voted them there, such as exemption from draft. Idea is to get citizens to serve as law makers and keep them on important job.

Getting good men to serve in legislature is tough job at best. It will get tougher if many law makers suffer same experience as Multnomah County legislator, who had his horse shot from under him while at the legislative wars.

Legislative gent took duties seriously, worked hard. Among other bills came along one in which building managers of state had vital interest. Legislator checked with his office landlord for data, later voted "right" on the bill. Shortly afterward hit ceiling upon receipt of notice at Salem his office lease was cancelled in what looked like effort to grab same space for incoming associate of fellow tenant who was friend of manager.

If building managers' association should have legislation at future session, they probably can rely on one sure vote—agin' 'em!

When Is Spring? Respected older Portland medico is so burned up at Shell Oil Company he now buys his gas from rival company. Shell outfit went to much trouble getting property at N. W. 19th and Hoyt; put in swanky new multiple-pump gas station. Doc, who makes triangle run from St. Vincent's to downtown office, to Physicians & Surgeons and Good Sam. hospital every day, thought it was a fine deal, patronized the place. But got one big miff when company cut down big chestnut tree alongside property. Turns out old-timer watched this tree for thirty years because it was first tree in Portland to crack buds in spring. Now he'll have to find another tree so he'll know it's spring!

Gobbledygook: Mid-Willamette doc who occasionally admits being "infernal pessimist" is having gala time decoding bureaucratic talk in copy of Dr. Dean Clark's group Voluntary Health Insurance report sent him from Washington. Calls it "Oscar" Clark report and will point out passage after passage he thinks "loaded." Considers it Oscar Ewing's "third round propaganda," and gets Big Satisfaction pointing out places government is "invited in."

Expects recommendation continued study of problem with senate committee itself coordinating efforts and participation by "Organizations representing medical care carriers, major population groups and governmental agencies" to be nothing but bid to continue propaganda. Gets laugh out of suggestion in covering note which accompanied report "Government Printing Office may reprint the report and

establish a price." Claims no doubt "demand" built up by propaganda needs of Oscar and his pals will "force" G. P. O. to "reprint" report, points out "price" is just a trick to make suckers think propaganda is paying its own way.

So far, hasn't come up with single doc willing to dispute gobbledygook decoding, but some of his colleagues are beginning to wish he'd be less persistent letting them in on his fun!

New Officers Elected at Eastern Oregon Medical Meeting

A well-planned panel of discussions, featuring two speakers of the Third Annual Extramural Postgraduate Cancer Lecture Series, drew a fine attendance of 66 physicians to the Eastern Oregon District Medical Society meeting last month at La Grande.

At the business meeting, C. Palmer McKim, Baker, was elected president. Other officers elected were: Flora C. Biswell, Baker, vice-president, and Warren F. Bolton, Elgin, secretary-treasurer.

A new committee, the Grievance Committee, was appointed to consider establishment of an average fee schedule for physicians in Eastern Oregon Medical Society. This committee will consider the matter and make their report at the next annual meeting. Serving on the committee are Robert W. Pollock, Baker, chairman; Roderic Belknap, Ontario; Lyle C. Ham, Enterprise; James J. D. Haun, La Grande, and Edward S. Morgan, Pendleton.

The O. P. S. Supervisory Committee, whose function is that of supervising the administration of O. P. S. in the Eastern Oregon area, has two new members: Neal E. McCarthy, Vale, and John R. Higgins, Baker. Other members of the committee are Edwin G. Kirby, La Grande; Louis J. Feves, Pendleton, and William J. Kubler, Prairie City.

New member of the Board of Censors is C. L. Gilstrap, La Grande. Other members of the board, which reviews applications for membership to Eastern Oregon Medical Society, are: Kenneth E. Kerby, Nyssa, and C. Palmer McKim, Baker.

Baker will play host to the 1952 meeting of the Society, and the dates chosen for next year's meeting are June 20 and 21.

Notes from the Medical School

It was graduation day at the University of Oregon Medical School, Friday, June 15—a memorable day for 71 medical school students who left the campus with their degrees of Doctor of Medicine. Among the young doctors were 23 who, besides their degrees, also were commissioned in the U. S. Army, U. S. Air Force and U. S. Naval Reserve.

Laurence Selling, M.D., Professor Emeritus of the Medical School, highlighted the commencement exercises with his address to the graduating class.

Department of Nursing at the Medical School conferred diplomas of nursing on 45 student nurses on Friday, June 8. Twenty-three of the nurses also received Bachelor of Science degrees.

In the past six weeks, the University of Oregon

Medical School has been endowed with a number of very fine and worthy gifts and grants. On June 19 they were approved by the Oregon State Board of Higher Education, as follows:

A grant of \$24,000 from the Office of Naval Research for extension of a contract with the University of Oregon Medical School to be expended under the direction of Archie Tunturi, assistant professor of anatomy for continuance of his work on the anatomy and physiology of the auditory system.

A grant of \$14,000 from the Atomic Energy Commission as an extension of their contract with the Medical School to be utilized under the direction of E. S. West, professor and head of the Department of Biochemistry, for continuation of studies on metabolism of cholesterol and ketone bodies.

A gift of \$10,000 from the estate of Miss Florence Rybke to be known as the Charles L. Rybke Fund in memory of her brother. Income accruing from investment of this fund shall be used in support of needy and worthy students at the University of Oregon Medical School.

A grant of \$10,000 from the Office of Naval Research for extension of contract with the Medical School for research under direction of Arthur W. Frisch, associate professor of bacteriology.

A grant of \$5,275 from the National Foundation for Infantile Paralysis to be expended under the direction of Arthur W. Frisch, associate professor of bacteriology.

A donation of \$2,500 from Dr. Esther P. Lovejoy to be added to a fund already on hand for the Pohl Memorial Prize Fund. This fund is utilized for scholarships for medical students.

A grant of \$2,000 from Parke, Davis & Company to be used for research in the Pharmacology Department under direction of Elton L. McCawley, associate professor of pharmacology.

A donation of \$300 from the University of Oregon Medical School Alumni Association for out-of-state travel funds.

A gift of \$175 from Parke, Davis & Company to be utilized in helping with construction of a display case in the Department of Pharmacology.

Regional Blood Center Is Brilliant Success

Even to the most casual eye, the operation of the Regional Blood Center in Portland would be fascinating. The extensive inner workings of this unique operation are even more interesting. This blood center, operated jointly by the Red Cross and the Multnomah County Medical Society, is one of the finest in the country. At 1506 S.W. Alder Street, Portland, is a completely equipped and flawlessly operated fixed unit. In addition to this, there are three mobile units and the Army Air Force has put two airplanes at the disposal of Nicholas P. Sullivan, medical director. The net result has been that the Portland Regional Blood Center has been able to meet the military needs for whole blood and plasma, without burden to the civilians in the area.

At request of the Multnomah County Medical Society, the twenty-first American Red Cross Regional Blood Center opened in Portland in February, 1949,

with a staff of fifteen. The staff included at that time Nicholas P. Sullivan, medical director, an administrator and his assistant, two laboratory technicians, a statistician, two custodians and three secretaries. In the first full month of operations, March, 1949, with a total of 786 units of blood collected, the personnel needed for such an operation was augmented by volunteer help, recruited and trained by Red Cross. This group gave an average of one or two days a week and included nurses aides, canteen workers, laboratory assistants, hostesses, gray ladies and staff aides as typists, clerks and filists.

Hospitals, doctors and clinics were included in a survey made to determine the estimated need for whole blood in this area. Estimates were surprisingly close to the national figure set for the region on a basis of population. Hospitals estimated they would need 29,000 pints in 1950 and the quota set for the area was 30,000 pints per year. During 1950, a total of 32,220 pints was collected. This figure would indicate that the area had reached saturation point. Factually, however, the war in Korea changed the picture considerably for the last half of 1950.

The region was asked to send Red Cross whole blood and plasma to the Armed Forces. The American Medical Association assured civilians that their needs would be met and that the burden of accelerated recruitment would be the responsibility of the Red Cross and the community. Several counties in Oregon and Washington agreed to donate blood for Korea, although they were not actually in the program. These



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counties are Lane and Coos in Oregon; Pierce, Thurston and Grays Harbor in Washington. Present quota of the Portland center for military usage is 3,500 units per month.

Actual demands increase as the situation in Korea dictates and emergency calls are met as nearly as possible. One of the problems in meeting military needs is the requirement that blood reach Cutter Laboratory in Berkeley, Calif., and be processed within 72 hours from the time of drawing. This often creates a shipping and refrigeration problem difficult to handle.

Blood derivatives now available through Red Cross include plasma, immune serum globulin, serum albu-



View of one section of the laboratory for the Portland Regional Blood Center. Mrs. Elizabeth Fitzmaurice in the foreground is central supply supervisor and Miss Rose Pawluck, chief technician. Door in rear opens into plasma pooling room.

min, fraction one, and irradiated plasma. The recent epidemic of measles in Portland and surrounding territory required distribution of 2,800 units of immune serum globulin.

There are now 34 counties in Oregon and Washington participating in the Red Cross blood program and expansion into other counties is anticipated. The area now serves 56 hospitals. Blood collections in the first five months of 1951 averaged 5,500 pints per month. With military needs set at 3,500 and civilian needs at 2,500 pints per month, a deficit of 500 pints per month must be met. The Portland Regional Blood Center now operates with a staff of approximately 50 with a volunteer staff giving more than 2,000 hours per month.



1950 - 1951 Oregon State Medical Society Component Societies

Baker County Society	
President, J. R. Higgins Baker	Secretary, R. W. Pollock Baker
Benton County Society	
President, B. Goldberg Corvallis	Secretary, D. L. Smith Corvallis
Central Oregon Society	
President, J. W. Thom Bend	Secretary, E. A. Moody Bend
Clackamas Co.nty Society	
President, F. J. Diefickx Oregon City	Secretary, W. R. Eaton Oregon City
Clatsop County Society	
President, N. B. Rawls Astoria	Secretary, K. Grant Warrenton
Columbia County Society	
President, J. B. Steward St. Helens	Secretary, O. L. Zeschin St. Helens
Coos and Curry County Society	
President, G. E. Stark Coquille	Secretary, W. J. Corrigan North Bend
Douglas County Society	
President, E. E. Lindell Roseburg	Secretary, J. G. Verberkmoes Roseburg
Eastern Oregon District Society	
President, E. G. Kirby La Grande	Secretary, W. H. Alden John Day
Jackson County Society	
President, A. J. Loeffler Trail	Secretary, C. W. Lemery Medford
Josephine County Society	
President, J. P. Russell Grants Pass	Secretary, V. A. Coverstone Grants Pass
Klamath County Society	
President, J. D. Merryman Klamath Falls	Secretary, G. E. Cosgrove Kalamath Falls
Lake County Society	
President, J. H. Robertson Lakeview	Secretary, W. J. Strieby Lakeview
Lane County Society	
President, L. A. White Eugene	Secretary, K. D. McMillan Eugene
Lincoln County Society	
President, O. N. Callender Toledo	Secretary, H. D. Barker Newport
Linn County Society	
President, A. S. Jensen, Jr. Albany	Secretary, R. A. Martin Albany
Malheur County Society	
President, C. E. Palmer Ontario	Secretary, R. Belknap Ontario
Marion-Polk County Society	
President, B. A. Myers Salem	Secretary, R. F. Anderson Salem
Mid-Columbia Society	
President, J. H. Skirving The Dalles	Secretary, M. D. Merriss The Dalles
Multnomah County Society	
President, J. C. Adams Portland 5 Medical-Dental Bldg.	Secretary, V. D. Sneed Portland 1 3181 S.W. Sam Jackson Park Rd.
Tillamook County Society	
President, J. I. Codd Tillamook	Secretary, R. E. Rinehart Wheeler
Umatilla County Society	
President, G. Smith Pilot Rock	Secretary, W. R. Weissert Pendleton
Union County Society	
President, R. L. Stuart La Grande	Secretary, W. F. Bolton Elgin
Wallowa County (Inactive)	
Washington County Society	
President, R. S. Welsh Beaverton	Secretary, L. Thompson Beaverton
Yamhill County Society	
President, C. A. Bump Newberg	Secretary, H. Shumway McMinnville

WASHINGTON STATE MEDICAL ASSOCIATION



ANNUAL MEETING SEATTLE, SEPT. 9-12, 1951

President, K. L. Partlow, M.D., Olympia

Secretary, J. W. Haviland, M.D., Seattle

Executive Secretary, Mr. R. W. Neill, Seattle

A. M. A. Convention News Briefs

Physicians owe it to themselves and to the nation to stay in politics, U. S. Senator Nixon of California told the Conference of Presidents and other officers of state medical associations. He also commended the medical profession for taking a leading role in supplying voluntary financial aid to medical schools and urged greater activity in spreading voluntary health programs.



MR. R. W. NEILL

R. D. Wright, Tacoma, W. S. M. A. delegate to the A. M. A. and member of the executive committee of the Conference of Presidents, was chairman of the nominating committee for the Conference. His report was adopted unanimously.

Medical students (2) were seated in the A. M. A. House of Delegates at Atlantic City for the first time in history. They were the delegates of the recently organized Student American Medical Association.

Elmer Henderson left the A. M. A. presidency with many physicians calling him the "best president we ever had." That's a tough record for the new president to face, but if any one can match that accomplishment, it is conceded that John Cline of California can. Stand Louis Bauer, new president-elect, alongside Henderson and Cline and you have a combination hard to beat in any organization.

Mr. Ralph W. Neill, executive secretary, Washington State Medical Association, was elected to the executive committee of the Medical Society Executives' Conference, an organization of executive officers of state and county medical societies having A. M. A. approval.

A. M. A. Board of Trustees announced plans for appointing a committee of prominent laymen representing industry, labor, agriculture, education, the bar and clergy, to advise it in matters of medical care and to present the viewpoint of the general public. It will be several weeks before names will be announced.

The American College of Radiology announced it had voted \$2,000 for the American Medical Education Foundation. Other organizations are making similar plans. It appears the idea is catching on and the \$1,000,000 goal set for 1951 contributions of physicians and medical organizations will be reached.

Easterners won the honors in the A. M. A. golf tournament, in which 264 physicians participated. D. H. Houston of Seattle is permanent chairman of the Advisory Committee of the A. M. A. Golf Association.

The House of Delegates approved a resolution requesting Congress to investigate activities aimed at indoctrination of students in grammar school, high school and college with "the insidious and destructive tenets of the welfare state."

The Woman's Auxiliary to the A. M. A. presented President Henderson with a check for \$10,000 for aid to medical schools. That amount represents 20 per cent of the Auxiliary's annual income.

Arnold C. Tait, Sunnyside; John K. Davis and Benjamin T. Terry, Tacoma; Claude H. Weitz, Tekoa; Floyd L. Dunnawan, Vancouver; Joseph Schiff, Walla Walla, and Ralph L. Uber, Yakima.

More news reporters covered the A.M.A. Convention activities this year than ever before, with 78 science writers representing 58 newspapers, wire services, magazines and publishing houses reporting on the scientific presentations and actions of the scientific meetings and House of Delegates. This indicates an ever-increasing interest in A.M.A. activities and is bound to produce a better feeling toward the medical profession.

Dr. Henderson, in his retirement address to the delegates, revealed that the recommendation of Whitaker and Baxter to terminate the National Education Campaign at the end of 1951 had been accepted. This announcement prompted resolutions from four states urging retention of the campaign directors for another year and upon request by the delegates, the Board of Trustees acceded. Thus the campaign rolls on. Whitaker and Baxter were lauded by Henderson for their work and highly praised by the delegates for their devotion to the cause.

(Continued on Page 524)

"Beck Broadcast at Atlantic City a Smash Hit" DOUGLASS



"Government Medicine Cannot Be Tolerated", says this six-page pamphlet that goes out to 180,000 teamsters and their families . . . mailed from Seattle.

The Dave Beck broadcast at the A.M.A. convention in Atlantic City June 11 was a smash hit with the doctors, and was engineered and directed, in large part, by medical men of the Pacific Northwest, according to Frank H. Douglass, Seattle, chairman of the Public Relations Committee of the Washington State Medical Association.

Mr. Beck is executive vice-president of the International Brotherhood of Teamsters, American Federation of Labor. His address was delivered in the Hotel Traymore, Atlantic City, N. J., as one of the main events of the 100th Annual Session of the American Medical Association. His speech went out to an estimated 27 million listeners on two nation-wide networks.



FRANK H. DOUGLASS
Public Relations Chairman of the Washington State Medical Association

"Mr. Beck is a Seattle man who is considered to be one of the leading labor executives of America. A quarter million copies of his A.M.A. speech, entitled 'Government Medicine—Danger Ahead,' were printed in Seattle for the Teamsters Union and were mailed by the teamsters to their 180,000 members throughout the United States.

"An additional quarter million copies are being printed by the Public Relations Department of the A.M.A. for distribution to doctors throughout the nation. It is estimated that the broadcasts, the news releases and the printed folders will have reached better than a third of the voters of the nation before the publicity program is concluded," Douglass said.

Plans for inviting Mr. Beck to address the convention were initiated by Washington State representatives at the Cleveland meeting of the A.M.A. last December at which time another well-known labor leader was a principal speaker. A. G. Young of Wenatchee, a Washington state delegate to the A.M.A., immediately proceeded on the suggestion and placed the proposal before the proper A.M.A. officials. John Cline, then president of the A.M.A., personally extended the invitation to Mr. Beck some two months ago when the two were together on a government-sponsored orientation trip inspecting major defense projects of the nation. Dr. Alexander Grinstein of Seattle, close personal friend of Mr. Beck, accompanied the labor leader to and from the convention.

"Thus, Mr. Beck and his teamsters and the A.M.A. delivered another convincing argument against socialized medicine," concluded Douglass.

Excerpts from Beck Speech

" . . . GOVERNMENT MEDICINE CANNOT BE TOLERATED . . . "

"The doctor in America has won his present high place in the hearts and spirits of our people through his study, toil, sacrifice and service. The long story of

medical progress is written in thrilling chapters of service to humanity—by unknown research workers

(Continued on Page 530)

The Board of Trustees has authorized expansion of its Physician Placement Service, through which many communities may obtain assistance in getting doctors. This placement service keeps in constant contact with state medical associations, thus bringing openings and unattached doctors, or those wishing to change locations, together.

More than twenty special medical programs were recorded in Convention Hall for broadcast to English-speaking countries by the Voice of America. Leading off the series is an address by the new president, John W. Cline, on "The Doctor in the American Community." Most of the broadcasts will be on scientific subjects.

Louis Bauer, new president-elect, is a New York cardiologist whose capabilities as a leader have brought him to the forefront on the county, state, national and international medical scene. He has been chairman of the A.M.A. Board of Trustees since 1949, is the secretary-general of the World Medical Association, served as chairman of the A.M.A. Council on Medical Service from 1943 to 1944 and was a member of the House of Delegates for three years.

In his election address before the delegates, Bauer emphasized this as the time for constructive action and said our voluntary insurance program "must be expanded to fill the gaps in coverage which still exist."

He said the "whole profession must be brought enthusiastically behind this program."

Washington Physicians Attend A. M. A. Convention

Washington State had a goodly number of physicians registered at the A. M. A. Convention in Atlantic City. They were: K. L. Partlow, Olympia, president of the Washington State Medical Association; R. L. Zech, Seattle; R. D. Wright, Tacoma, and A. G. Young, Wenatchee, delegates to the A. M. A.

Others are: From Seattle—George H. Allison, Joel W. Baker, Albert L. Banks, S. N. Berens, Francis H. Brown, Walter Scott Brown, Joseph A. Buchmeier, James M. Casey, Francis E. Flaherty, Samson Goodglick, Stephen Grega, George A. Hanson, D. H. Houston, Robert L. King, E. K. Knott, Frederick Lemere, James W. Miller, Daniel C. Moore, Lloyd H. Mousel, Warren H. Orr, Lester J. Palmer, Donal R. Sparkman, William C. Speidel, Frederic E. Templeton, Roger S. Thompson, Walter L. Voegtlin and R. H. Williams.

From Spokane—R. E. Ahlquist, Emory F. Baker and Joseph R. Fox. Also attending were: Edward W. Nash, Cashmere; Harry H. Kretzler, Edmonds; Edwin R. Tiffin, Enumclaw; Clarence M. Leary, Goldendale; Herbert H. Minthorn, Longview; H. A. Gilbert, Mt. Vernon; Charles E. McArthur, Olympia; Stuart W. Holmes, Oroville; B. B. Forman and H. L. Kennedy, Shelton; Bruce C. McIntyre, St. John.

Medical Notes

GROUP BLOOD DONATION PLAN BECOMING POPULAR. Spokane Blood Bank's "Monday night for group donations" is proving popular, Oscar Christianson, director, has announced. Thirty residents of Metaline Falls and Ione, Wash., drove to Spokane last month to give blood donations to "pay for" blood sent by the bank to hospitals in those Inland Empire towns. Part of this donation was set aside for patients in the Spokane Veterans' Hospital. A dozen North Hill Masonic Lodge members came to the bank after their Monday night meeting and donated blood. Dr. Christianson said the blood bank remains open every Monday night until 8 o'clock to take care of group donations.

"MYTH" OF CURES EXPLODED. The "myth" that cures are available for sex offenders was exploded by Sol Levy when he read a paper recently before the Washington State Association of Prosecuting Attorneys. The meeting was held in Spokane, June 9. Dr. Levy is a member of the staff at Eastern State Hospital at Medical Lake.

"We have no way of successfully treating the sexual psychopath at the present time," Levy said. He mentioned that basic research is necessary to find the actual causes of sex perversions and abnormal sex behaviors. Present information causes him to fear, he said, that a majority of cases of abnormal sex behavior are not the result of emotional, mental, organic or environmental disorders, but of unknown causes.

"It is this type of offender for whom psychiatry at the present time has nothing to offer, except close custodial care," he pointed out.

FORTY-SEVEN RECEIVE MEDICAL DEGREES AT UNIVERSITY OF WASHINGTON. Forty-seven young men and women became doctors of medicine on June 9 at the University of Washington School of Medicine. This class of 1951 is the second medical class to be graduated by the University. The new doctors will become interns at medical institutions throughout the world. One is going to take his internship in Norway, two others are taking Reserve Officers Training Corps internships at military hospitals. Five of the 47 graduates are women.

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Society Meetings

COWLITZ COUNTY MEDICAL SOCIETY. Techniques of surgery dealing with congenital and acquired heart diseases were explained May 16 for members of the Cowlitz County Medical Society at a dinner meeting in the Hotel Monticello, Longview. Speaker was William S. Conklin, chief of chest surgery of the University of Oregon Medical School.

Robert L. Pulliam spoke on the use of anti-coagulants to prevent pulmonary embolism after surgery.

SEATTLE DOCTOR NAMED TO COUNCIL. John F. Tolan, Seattle, was elected to the council of the Pacific Coast Oto-Ophthalmological Society at its meeting in Victoria, B. C., recently. H. L. Goss, Seattle, also is on the council. Lewis F. Morrison, San Francisco, was elected president of the society.

PHYSICIANS SELECT SPEAKER. Spokane Academy of General Practice has announced that guest speaker at their December 1 annual meeting will be Philip Thoreck of the University of Illinois Medical School faculty. The May 22 meeting of the group at Sacred Heart Hospital, Spokane, featured papers on hospital radiology, hospital pharmacy and the hospital laboratory and pathology department. Speakers were Robert Sagerson, C. L. Sundberg and John Hill. R. M. O'Brien presided.

Hospital News

DOCTORS PLAN NEW HOSPITAL. Physicians associated in the New Riverview Clinic, Raymond, have acquired property in a suitable location and are planning to erect a hospital and clinic. The building will replace the present New Riverview Hospital and will allow for five doctors' offices, a 17-bed hospital section and space for professional offices.

AIR RAID SHELTERS URGED IN HOSPITALS. Federal Civil Defense Administration is urging inclusion of air-raid shelters in both new and existing hospitals in the Pacific Northwest. Mr. Roger E. Dunham, regional director of the F.C.D.A., announced recently. Dunham said federal authorities are asking Congress to provide matching funds for such shelters and other protective features. He also mentioned that F.C.D.A. is anxious that any new hospitals be built "outside or on the rim of designated critical target areas."

HOSPITAL OFFICIALS VISIT COAST INSTITUTION. Preparing for the affiliation of Central Washington Tuberculosis Hospital with St. Elizabeth's Hospital of Yakima, A. R. Allen, medical director, and Mrs. Jessica McWhirter, superintendent of nurses at the Selah institution, made a trip to Seattle recently to observe practices in the Firland sanatorium. Under the new plan, student nurses from St. Elizabeth's will spend six weeks of their senior year in service in the Selah hospital.

HOSPITAL WING IS DEDICATED. Everett General Hospital's new wing, the Eleanor E. Butler Maternity Home, was dedicated May 25. Raymond B. Allen, president of the University of Washington, delivered the dedicatory address. The wing, built at a cost of more than half a million dollars, was bequeathed to the hospital by the late William C. Butler in memory of his wife.

NEW HOSPITAL AT COLVILLE. Construction started June 12 on the new 50-bed Mount Carmel Hospital at Colville. Funds to complete the hospital are still being sought by the hospital fund drive committee. Mr. Joe Stricer, finance chairman of the committee, said efforts would be continued to raise all of the funds needed to finish the hospital. The only way it can be completed is for the entire community to get behind the current fund campaign, he said.

DRIVE STARTS FOR BIG HOSPITAL IN WEST SEATTLE. A campaign is being started to build a 300-bed hospital to serve Southwestern King County, Mr. E. H. Savage, president of the Sound View General Hospital Corp., announced recently. The hospital, which will cost about \$4,650,000, will be constructed near Delridge Way and West Orchard Street. It will serve West Seattle, Southwest Seattle, White Center, Southern King County, Burien, Des Moines and Vashon Island. An estimated population of 300,000 persons in this area has fewer than 30 hospital beds in the area to serve them, Savage, a West Seattle businessman, said. He explained that if 60 per cent of the cost of the hospital is raised by public subscription, the federal government will provide 40 per cent.

MEDICAL STAFF HEADS ELECTED. Election of Henry V. Bories as president of the Providence Hospital medical staff was announced May 22. Other officers are Bernard E. McConville, president-elect, and S. N. Berens, secretary-treasurer.

John K. Martin, Francis E. Flaherty, Robert F. Foster and Raymond L. Zech were named to the executive committee and Frank J. Leibly, William J. Foley, John W. Codling, William P. Yunk and Foster to the record committee. They were installed at the staff's annual dinner June 9.

Personals

Russell R. de Alvarez, professor and executive officer, department of obstetrics and gynecology, University of Washington School of Medicine, was elected to membership in the American Gynecological Society at the 75th anniversary meeting held in May, 1951. Scene of the meeting was the Waldorf Astoria Hotel in New York City where the society was founded 75 years ago. Total membership of the group is about 95. Dr. de Alvarez presented a paper at the May, 1950, meeting in White Sulphur Springs, W. Va., entitled, "Renal Function in Pregnancy Toxemia."

Edwin S. Bennett, superintendent of the King County Hospital System, has been elected to head the professional division of the Seattle-King County Community Chest & Council campaign for the second consecutive year. Dr. Bennett recently was re-elected first vice-president of the Seattle-King County Health and Welfare Council. He is a member of the Community Chest Board of Directors.

An old grad with a vision had the place of honor at the commencement exercises of the University of Washington, June 9. Dr. Alfred S. Strauss of Chicago, 1904, received the University's highest alumni award, "Alumnus Summi Grade Dignatus." His selection for the distinguished alumnus award for 1951 was an-

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nounced last January. The prominent Chicago surgeon sees a great future for the University of Washington School of Medicine.

"Seattle, with New York and Chicago, could become one of the three great medical centers of the United States," he said. "As far as we've gone, we have as fine a set-up at Washington as any in the country. There is nothing better or more modern."

Dr. Strauss praised the quality of the medical school's staff which he said includes some of the outstanding men of the country.

In recognition of "fifty years of faithful and honorable service of the art and science of medicine," Frederick J. Hackney, Centralia, has been awarded the golden anniversary diploma by Wayne University College of Medicine Alumni Association. Dr. Hackney graduated from the Wayne College of Medicine in 1901 in a class of about 50. He retired from active practice "gradually," as he puts it, about eight years ago. He had practiced in Centralia since 1918, coming to the city from Nevada.

Paul Lee, Coulee Dam physician, departed June 5 to report for military duty at Fort Sam Houston at San Antonio, Texas. Lee studied at Creighton University, Omaha, for his medical degree and served in the army during World War II. He has practiced medicine at Coulee Dam for about three years.

Maynard L. Johnson, young Mount Vernon physician, has been ordered to report immediately for active duty in the U. S. Army. Dr. Johnson will begin his training in Texas. His family plans to remain in Mount Vernon.

Donald A. Crosiar, former Pasco physician, is now with the Department of Health for the government of Puerto Rico, he wrote Pasco friends recently. He reported he has been contemplating such a move for the past three or four years and hopes to do part-time private practice and will take his patients to the new Seventh Day Adventist Hospital at Mayaguez. It is one of the few modern hospitals on the island, he said. Mrs. Crosiar and family will join him in a few months.

Auxiliary

COWLITZ COUNTY. New officers of the Woman's Auxiliary to the Cowlitz County Medical Society were elected at a dinner meeting at the Hotel Monticello, Longview, May 16. They are: Mrs. H. D. Fritz, president; Mrs. J. L. Norris, vice-president; Mrs. H. D. Feusner, recording secretary; Mrs. C. V. Allen, corresponding secretary, and Mrs. R. M. Reynolds, treasurer. After the meeting, members were invited to the home of Mrs. H. H. Minthorn for a white elephant sale. Hostesses for the evening were Mrs. J. A. Nelson and Mrs. Minthorn.

GRAYS HARBOR. A dinner meeting was held at the Oakridge Club, Elma, in May to elect new officers for the Grays Harbor Auxiliary. Mrs. Arthur Skarperud is the new president succeeding Mrs. L. J. Hakala. Other new officers are: President-elect, Mrs. W. L. Hart; secretary-treasurer, Mrs. L. J. Semler; pro-

gram chairmen, Mrs. M. F. Fuller and Mrs. W. M. Hardy; public relations, Mrs. E. L. Calhoun and Mrs. J. E. Galbraith; historian, Mrs. M. P. Graham.

KING COUNTY. Members of the Woman's Auxiliary to the King County Medical Society gathered for a picnic luncheon at the home of Dr. and Mrs. Ernest Burgess, Mercer Island, May 21. New officers installed at the meeting were: Mrs. Purman Dorman, president; Mrs. Martin Norgore, president-elect; Mrs. James Blackman, first vice-president; Mrs. Olin Schreiner, second vice-president; Mrs. Robert Tidwell, third vice-president; Mrs. Sherod Billington, fourth vice-president; Mrs. Carl Helwig, treasurer; Mrs. Roger Johnson, recording secretary.

LEWIS COUNTY. Mrs. P. S. Garnett, Chehalis, was elected president of the Lewis County Medical Society Auxiliary at the recent meeting at the Centralia home of Mrs. George Kling, with Mrs. J. E. Toothaker assisting. Other officers are: Mrs. H. Y. Bell, president-elect; Mrs. Leonard Morely, treasurer; Mrs. R. B. Maddox, secretary.

YAKIMA COUNTY. A summer fashion show of "cottons worn around the clock" was presented when the Yakima County Medical Society Auxiliary met at the home of Mrs. Frank LeFor, May 7. Mrs. H. A. Gardener supplied the commentary on the show, which included summer cottons and accessories. Models were the Mesdames William F. Sims, E. Donald Lynch, H. C. Hines, C. G. Champoux and William L. Ross.



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State Convention Briefs

RESERVATIONS

Tentative convention plans call for meetings of the Board of Trustees on Saturday afternoon, September 8, and meetings of the Finance and Defense Fund Committees Saturday morning.

First session of the House of Delegates is scheduled for 2 p. m., Sunday, September 9.

Trustees and members of these two groups should make their hotel reservations with correct dates in mind.

SCIENTIFIC EXHIBITS

Requests for space in the Scientific Exhibits section are being received in goodly numbers. Those interested in this phase of the annual convention should send in their applications and requirements to Fred E. Cleveland, M.D., 338 Henry Bldg., Seattle. Deadline for applications is July 15.

TECHNICAL EXHIBITS

Sixty-four booths have been sold to commercial exhibitors and a dozen or more companies are on the waiting list, indicating Washington State Medical Association conventions have a wide following among drug and equipment concerns. These exhibits will be worthy of frequent visits, as the latest improved drugs and equipment will be shown. Attractive prizes will be given doctors who visit 40 or more exhibits and who draw the lucky numbers.

OLYMPIC BREAKS PRECEDENT

Annual banquet and dance will be held at the Olympic Hotel, instead of the Town and Country Club. The Olympic Hotel broke precedent and set aside the Georgian Room for the banquet. Refreshment hour will be held in the Olympic Bowl, where cabaret-style dancing will take place after the banquet.

GENERAL PRACTITIONER AWARD

No-host family dinner will be held in the Olympic Bowl Sunday, September 9, at which time the annual award for the Outstanding General Practitioner of the Year 1950 will be presented to Harry E. Rhodhamel of Spokane. Selection for 1951 will be made this fall.

COUNTY PRESIDENTS PLEASE NOTICE

Three county societies so far have failed to send to the state office names of their members of the House of Delegates. These counties are Lewis, Jefferson and Klickitat-Skamania. We must have these delegates' names in the very near future, or they will fail to receive important notices and the Report Book, which must be in their hands prior to the convention. Any changes or substitutions in the delegate lists

should be directed to the attention of the central office immediately.

SPORTS PROGRAM

Medical Association fishermen who enjoyed lake fishing during the Spokane convention last year, will thrill to the contrast provided by the big salmon of Puget Sound. This is reported to be a good salmon year. Golfers who have been familiar with the Seattle Golf and Country Club course will need to sharpen their eyes and swings this year to match the changes in the course. The new lay-out is in preparation for the U. S. Open event scheduled for next summer.

REMEMBER YOUR CONVENTION DATES—SEPTEMBER 9-12, INCLUSIVE—AND MAKE IMMEDIATE PLANS TO ATTEND THE ENTIRE PROGRAM!

MINNEAPOLIS WOMAN TO COME HERE

Mrs. H. F. Wahlquist of Minneapolis, president of the Woman's Auxiliary to the American Medical Association, will attend the annual sessions of the Woman's Auxiliary to the Washington State Medical Association in Seattle, September 9-12. Mrs. R. M. Schulte of Spokane, president of the Washington State Auxiliary, made final arrangements with Mrs. Wahlquist while attending the National Auxiliary convention recently in Atlantic City.

PHYSICIANS' ART AND HOBBY SHOW

Archie Powell of Seattle has been named chairman of the Physicians' Art and Hobby Show, which will be on display during the State Convention. Other members of the committee are A. J. Bowles and Paul Osmun, both of Seattle. Those who wish to enter either oil paintings, water colors, photographs, either black and white or colored, slides, etc., and hobby displays should notify Dr. Powell, 338 Henry Bldg., Seattle, at the earliest possible moment. Please designate number of articles you wish to enter and probable space needed.

COLLEGE OF SURGEONS CHAPTER

An organizational meeting of the Washington State Chapter of the American College of Surgeons will be held during the State Convention at the Women's University Club. The luncheon meeting is scheduled for 12:15 p. m. on Tuesday, September 11. Local chapters are being formed in many states in the hopes of creating mediums through which Fellows can take part in aiding the A. C. S. program of elevating hospital standards and facilities, and raising the plane of surgery over the entire country.

Obituaries

DR. DELMAR F. BICE, 68, Yakima, Wash., died May 23 of chronic myocarditis and bronchiectasis. Dr. Bice was graduated from Northwestern University Medical School in 1912 and practiced in Yakima county since 1913. He retired from active practice in 1946 because of poor health. A past president of Yakima County Medical Society, Dr. Bice had also served as chief of staff of St. Elizabeth's Hospital, Yakima. He was

president of the Washington State Medical Association in 1936-37 and served a term in the state legislature from 1935 to 1937. He was a fellow of the American College of Surgeons, of the International College of Surgeons and an associate member of the Seattle Surgical Society.

DR. JOSEPH LAMBERT HUTCHINSON, 78, Seattle, Wash., died May 20 of cerebral hemorrhage and arteriosclerosis. The physician was the father of three well-known sons—Freddie Hutchinson, the baseball player;

Dr. William B. Hutchinson, Seattle surgeon, and John L. Hutchinson, physical education director at Columbia University, New York City. The veteran Rainier Beach physician received his medical degree from Milwaukee Medical College in 1905 and came to Seattle in 1907. In his early days here, Dr. Hutchin-

son made his calls with a horse and buggy. Often he had to make his rounds by horseback when roads were impassable to buggies. Later, he acquired a Model T which became almost as famous as the doctor. Dr. Hutchinson was a fellow of the American Medical Association.

Health Department

Potent new insecticides now available to home gardeners are extremely hazardous to the user unless strict precautions are observed, J. A. Kahl, acting state health department director, warned recently in a letter sent to county and city health officers in the state.

Dr. Kahl identified the dangerous insecticides as those containing organic phosphates and explained that these substances are nerve poisons which can produce serious illness and death from absorption through the skin or mucous membrane or by being swallowed or inhaled. Small packages of organic phosphate insecticides, such as parathion and tetraethyl pyrophosphate, are being sold and recommended for home garden use, Dr. Kahl said.

"Be sure to read the label carefully if you buy any of these poisons," he emphasized. "The label will tell you what is in the insecticide and what precautions to observe when using it."

Organic phosphate spraying compounds have been in use in fruit orchards to kill insect pests. A research project is now under way in the apple orchards of Eastern Washington to study the poisonous effect of these chemicals.

An ordinance conforming with the state milk law and banning the sale of raw milk in Spokane was given a first reading before the city council at a legislative meeting May 28. J. B. Eason, city health officer, told the council the prohibition of the sale of raw milk is recommended on state and federal levels as one means of combating possible bacteriological war-

fare. The present city milk ordinance does not prohibit the sale of raw milk in the city. Dr. Eason has reported, however, that raw milk is not being sold in the city.

All types of medical care still will be provided for Washington's public welfare recipients, but it will be based upon real needs and applicants will be rigidly screened to make available funds meet costs. This announcement was made May 31 in a statement released by J. A. Kahl. Prepaid medical care contracts with state and local medical service bureaus have now been signed by the acting state health department director. These will provide emergency services for those on relief rolls at \$1.85 per month for each person. The new figure will be retroactive to May 1, when the previous \$2.75 rate was canceled because of a need to restrict the medical care program to only those services which were absolutely necessary. The practice of allowing welfare recipients a free choice of physicians wherever possible has been retained in the revised medical program, Dr. Kahl said.

An aerial assault will launch the drive to wipe out the year's mosquito crop in the Longview and Kelso area. The announcement was made May 26 by Donald Champaign, Cowlitz County health officer. He said a plane from Portland will fly low over sections of the two cities during the early morning hours, spraying lowlands and sloughs where mosquitoes breed. The program has been authorized by the county and cities of Longview, Kelso, Kalama and Woodland.

Spotlight on Service

Physicians Study Civil Defense Progress

Lack of funds for stockpiling medical supplies and obtaining emergency equipment is a serious concern to the civil defense committee of the Washington State Medical Association.

The committee, which consists of physicians who are chairmen of county society defense units, met recently with health officers in Seattle to discuss status of the medical-services program. The health officers are in over-all charge of local civil defense medical units.

Recent legislature provided \$258,000 for a department of civil defense (half of which is earmarked for salaries and wages) and an additional \$2,000,000 for disaster relief or matching of federal funds. Because there has been no federal money appropriated to date, there have been no purchases of first-aid supplies, firefighting equipment, etc. Seattle has appropriated \$100,000 in local funds, with several other counties

setting aside much smaller amounts from their own revenues.

Because there are not nearly enough doctors to take care of the needs of an atomic explosion, training of other health personnel for first-aid work had an important place in the agenda. A state-wide committee is being appointed to bring in dentists and veterinarians to work with the physicians to provide an adequate number of professional people qualified in first-aid. The Washington State Osteopathic Association is organizing a civil defense setup of its own, its activities correlating with the others through the State Health Department. An effort is also being made to standardize first-aid training given in all areas, so that teams which have the same training may be brought into disaster areas.

George E. Hoxsey of Wenatchee said Chelan County already has three surgical teams organized and ready

to travel, with four physicians and two dentists in each group.

High school science teachers will be the first group to be trained as radiological monitors, according to present plans. University of Washington, Washington State College, and Hanford Engineer Works are equipped to give training in this field.

The following physicians attended the meeting: Frank J. Leibly, chairman, Seattle; A. B. Murphy, vice-chairman, Everett; Scott S. Jones, vice-chairman, Tacoma; J. A. Kahl, secretary, State Department of Health, Seattle; Stanley R. Benner, alternate for Dr. Kahl, Yakima County Health Department; Maurice E. Bryant, Colfax; Milton P. Graham, Aberdeen; Robert M. Hill, Ellensburg; George E. Hoxsey, Wenatchee; W. L. Jackson, Burlington; Murray L. Johnson, Tacoma; Paul D. Mossman, State Department of Health, Seattle; J. L. McFadden, Port Angeles; R. R. Sachs, Richland; J. E. Toothacker, Centralia; Bruce Zimmerman, Seattle; J. Walton Darrough, Everett, and R. A. Bussabarger, Raymond.

The following health officers also attended: Wayne W. C. Sims, Seattle-King County Health Department; C. R. Fargher, Tacoma-Pierce County; A. H. B. Pederson, Kittitas County; S. P. Lehman, Seattle-King County; J. D. Fouts, Bellingham-Whatcom; Richard S. Munger, Lewis; Shirley Benham, Jr., Bremerton-Kitsap; H. L. McMartin, Snohomish; James E. Galbraith, Grays Harbor; C. R. Sharp, Walla Walla; Bernard Bucove, Thurston-Mason; Hampton H. Trayner, Whitman; Donald A. Champaign, Cowlitz-Wahkiakum; Malcolm G. Heath, San Juan, and Edward L. Van Aelstyn, Clark.

Participate in Rehabilitation Workshop

Four Washington physicians participated last month in a three-day workshop on rehabilitation, the business of helping build a normal and productive life for those suffering from handicaps.

Held on the University of Washington campus, the workshop was sponsored by the University's School of Medicine and Department of Psychology, the Anti-Tuberculosis League of King County, the King County Chapter of the National Foundation for Infantile Paralysis, the Washington Society for Crippled Children and Adults, and the Washington Tuberculosis Association. It was under auspices of the Puget Sound Chapter, National Rehabilitation Association.

On the opening day, participants were welcomed by Robert Ray, representing the School of Medicine, and Byron Francis, representing the Washington Tuberculosis Association.

Stephen Fleck of the Department of Psychiatry spoke on "Emotional Aspects of Disabilities." Harry S. Emmel, a Seattle orthopedist, took part in a panel on "Viewpoints on Rehabilitation," representing views of the medical profession.

Featured speaker was Roland H. Spaulding of New York, director of New York University's vocational rehabilitation curriculum study program.

Leaders Talk at Alcoholism Meet

A growing tendency to view alcoholism as a medical and social problem, rather than as an issue of morals,

was mirrored in a week-long seminar on "The Scientific Study of Alcohol" at the University of Washington last month.

Several Washington physicians participated in various phases of the program, which covered topics from economic costs and social disruption caused by this disease, to discussions of various therapy methods. The meeting was attended by physicians, social workers, public health officials and others interested in control of this pressing problem.

Washington physicians who spoke included: William R. Broz of Shadel Sanitarium, Gert Heilbrunn, S. Harvard Kaufman and Herbert S. Ripley, all of the department of psychiatry of the University's School of Medicine.

Other physicians who spoke included Andrew C. Ivy, vice-president of the University of Illinois, and Haven Emerson, one of the foremost figures in the public health movement.

Three university departments jointly sponsored the meeting—the Graduate School of Social Work, the College of Education and the School of Medicine.

WATCH FOR THE MAIL . . .

Some time during the next month, a pamphlet outlining in detail the Public Relations Program of the Washington State Medical Association will be mailed out to the medical profession of the state.

This pamphlet will emanate from the Central Office and will be distributed by county medical societies and auxiliaries.

Every doctor is urged to watch for this pamphlet and be sure it doesn't wind up in the waste basket. It is the first program of its kind to be adopted by the Washington State Medical Association and is the product of very careful study and research. The success of this program is predicated upon the individual physician participating in and supporting the organization of which he is a part.

The Public Relations Program is headed by Frank H. Douglass. Howard Barnes, Public Relations Director of Washington State Medical Association, will be available to assist county societies in establishing the program locally.

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Excerpts from Beck Speech

(Continued from Page 523)

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"We have been born as a great people and we will continue to thrive as a great people only under a system of free enterprise—free for the business man, free for labor, free for the doctors and free for all of our people."

Shaw Re-elected

Henry G. Shaw, Shaw Supply Co., Tacoma and Seattle, was re-elected president of the American Surgical Trade Association at the Association's mid-year meeting in Los Angeles last month. The Association, one of the first to be organized in the U. S., was celebrating its semi-centennial anniversary.

State T-B Association Meets

Forty physicians of the Pacific Northwest, mostly from Washington, attended the mid-year meeting of the Washington State Anti-Tuberculosis League in Spokane June 22-23. The meeting was held jointly with the Northwest Trudeau Society.

Principal out-of-state speakers included Robert C. Bloch of the University of Chicago School of Medicine and Joseph B. Stocklen, county T-B control officer of Cleveland, Ohio.



1950-1951 Washington State Medical Association Component Societies

Benton-Franklin Society	D. H. Eckles	Okanagan County Society	Secretary, B. J. Webster
President, R. R. DeNicola	Richland	President, T. P. Conners	Tonasket
Chelan County Society	First Wednesday—Wenatchee		Secretary, J. C. Proffitt
President, C. E. Conner	Secretary, F. R. Ellis	Pacific County Society, Third Thursday—Raymond and South Bend	Secretary, J. C. Proffitt
Cashmere	Wenatchee	President, O. R. Nevitt	South Bend
Clallam County Society	Second Tuesday—Port Angeles, Sequim		
President, H. J. Madsen	Secretary, J. J. Fairshier	Pierce County Society	Second Tuesday—Tacoma
Port Angeles	Port Angeles	President, J. F. Steele	Secretary, G. C. Kohl
Clark County Society	First Tuesday—Vancouver	Tacoma	Tacoma
President, D. R. Loree	Secretary, F. M. Butler	Skagit County Society	Fourth Monday
Vancouver	Vancouver	President, R. R. Rueb	Secretary, R. Hoag
Cowlitz County Society	Third Wednesday	Concrete	Concrete
President, H. H. Minthorn	Secretary, F. D. Morrison	Snohomish County Society	First Thursday—Everett
Longview	Longview	President, J. Meeske	Secretary, R. J. Wescott
Grays Harbor County Society	Third Wednesday—Aberdeen	Snohomish	Everett
President, F. J. Dwyer	Secretary, L. Semler	Spokane County Society	Second Thursday—Spokane
Aberdeen	Hoquiam	President, R. D. Reekie	Secretary, G. T. Wallace
Jefferson County Society		Spokane	Spokane
President, R. E. Fallis	Secretary, H. G. Plut	Stevens County Society	Secretary, M. B. Snyder
Port Townsend	Port Townsend	President, J. E. Blair	Chewelah
King County Society	First Monday—Seattle	Chewelah	
President, D. Metheny	Secretary, F. A. Tucker	Thurston-Mason Counties Society	Fourth Tuesday—Olympia
Seattle	Seattle	President, R. Highmiller	Secretary, H. B. Frank
Kitsap County Society	Second Monday—Bremerton	Olympia	Shelton
President, H. A. Barner	Secretary, F. Rosendale	Walla Walla Volley Society	Second Thursday—Walla Walla
Bremerton	Bremerton	President, M. W. Tompkins	Secretary, L. O. Carlson
Kittitas County Society	First Tuesday—Ellensburg and Cle Elum	Walla Walla	Walla Walla
President, Arthur Clark	Secretary, Floyd Rogalski	Whatcom County Society	First Monday—Bellingham
Ellensburg	Cle Elum	President, A. G. Zoet	Secretary, P. E. Rowe
Klickitat County Society		Bellingham	Lynden
President, J. R. Rehal	Secretary, D. G. Moody	Whitman County Society	Third Wednesday—Colfax
Stevenson	White Salmon	President, M. K. Turner	Secretary, W. S. Butts
Lewis County Society	Second Monday—Centralia and Chehalis	Pullman	Pullman
President, Robert Fulton	Secretary, Rush Banks	Yakima County Society	Second Monday—Yakima
Chehalis	Centralia	President, R. D. McClure	Secretary, W. H. Gray
Lincoln County Society		Yakima	Yakima
President, E. R. Salter	Secretary, J. E. Anderson		
Davenport	Wilbur		

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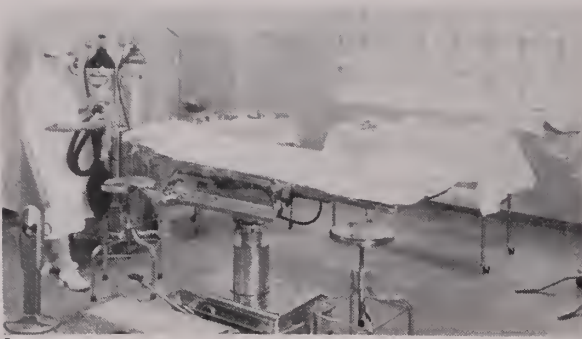
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Veterans Home Care Plan, Five Years Old, Renewed by Young; \$16,346 to Doctors in June

Renewal of the contract between the Washington State Medical Bureau and the Veterans Administration Home Care Plan was announced by John Steen, bureau manager, upon his return June 25 from Washington, D. C.

Mr. Steen and his wife attended the A.M.A. convention in Atlantic City June 11-14, made business calls in the nation's capital and found some time for vacationing on their leisurely trip back to Seattle.

The Washington State contract was signed by A. G. Young of Wenatchee, bureau president, and was then taken to Washington, D. C., by Steen for the Veterans Administration signature, effective as of July 1 for the period of one year. The contract was initiated in April, 1946.

The significance of the Veterans contract is indicated by the fact that Steen's office in Seattle during the month of June paid out \$16,346 in claims to approximately 1,100 state physicians.

While attending the convention Steen met with the A.M.A. Council on Medical Service and the committee on Veterans Home Care Plan.

"I found all delegations from east of the Rocky Mountains intensely interested in the service type of coverage that we have in Washington as opposed to the indemnity type that is generally established throughout the eastern states," Steen declared. "Physicians and administrators, as well as subscribers, are demanding the newer type of insurance," he stated.

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**IDAHO STATE
MEDICAL ASSOCIATION**

**ANNUAL MEETING
JUNE 15-18, 1952
SUN VALLEY**

President, A. M. Popma, M.D., Boise

Secretary, R. S. McKean, M.D., Boise

Executive Secretary, Mr. A. L. Bird, Boise

Medical Notes

NORTH IDAHO DISTRICT MEDICAL SOCIETY. May 16 meeting of the society was held at the Bollinger Hotel, Lewiston. F. O. Graeber, State Department of Public Health, Boise, was introduced to the members. Speakers on the program were Frank Fletcher, Boise, who discussed Congenital Heart Disease, and Jerome Burton, Boise, who spoke on Orthopedic Conditions About the Elbow. A report was given on the relationship of member physicians from Asotin County, Washington. It was moved that the society constitution be altered to extend courtesy privileges to physicians in nearby Washington cities.

June 13 meeting of the society took place at the Moscow Hotel, Moscow. Papers were presented by three Spokane pathologists, Theodore Ludden, Jack Hill and Oscar Christianson. During the business meeting the application for membership of Charles A. Robbins was read and unanimously approved.

POSTGRADUATE CANCER COURSE AVAILABLE TO IDAHO PHYSICIANS. A selection of some thirty physicians from all parts of Idaho to go to Portland for the annual postgraduate cancer course at the University of Oregon Medical School will be made. The announcement was made by Raymond L. White, chairman of the executive committee of the Idaho Cancer Society. He said invitations will be sent soon to doctors selected for the course which will be held September 24-28. The Idaho State Medical Association's cancer committee and other members of the Cancer Society's Board of Directors will make the selection of physicians to take the course.

SOUTH CENTRAL IDAHO SOCIETY. Monthly business meeting of the society was held at Burley, May 8. J. Woodson Creed, Twin Falls, president, introduced the speakers. Harold Brown, assistant chief medical officer of the Salt Lake City Veterans Hospital, addressed the gathering on Chronic Liver Diseases. A discussion of the new disease, Q Fever, was presented by R. T. Jellison, United States Public Health Laboratory at Hamilton, Montana.

HEART ASSOCIATION CLINIC. A two-day refresher course on heart disease, sponsored by the Idaho Heart Association, was held in Pocatello, June 1-2. Four leading researchers in cardio-vascular diseases presented lectures during the two days. These included: H. H. Hecht, University of Utah Medical School; H. E. Griswold, Jr., University of Oregon Medical School; W. W. Hurst, research fellow of the American Heart Association, and Robert Bruce, University of Washington School of Medicine. Burton Stein, Lewiston, is president-elect of the Idaho Heart Association and will take office at the next annual meeting of the

group to be held next spring. Other officers named at the June meeting were Richard Howard, Pocatello; O. F. Swindell, Boise, and Harvey Hatch, Idaho Falls, regional vice-presidents; Glenn Voyles, Twin Falls, secretary, and William Goodall, Boise, treasurer.

IDAHO HEALTH DEPARTMENT. T. O. Carver, chief of Idaho Health Department's preventive medicine section, announced recently that more than 2500 blood tests for syphilis were taken in a three-week drive in Pocatello. He said the program was first of its kind in the Intermountain area. Tests were made on a voluntary basis. Results will be determined later.

TWO PHYSICIANS NAMED TO HEAD HOSPITAL DRIVE. J. Robert Mangum and A. B. Halliday have been appointed by directors of the Nampa United Hospitals Fund as solicitation chairmen of the medical division, Mr. Edson H. Deal, fund president and drive chairman, announced recently. The medical division began its campaign May 9. A committee of physicians will be named by the division co-chairmen to assist in solicitation.

Goal of the joint drive for the two Nampa hospitals is \$300,000. The money asked for will be used to build a heating plant and a laundry apart from the main building at Mercy, and to put into operation a new wing at Samaritan. All funds collected will be shared equally by the two institutions, Deal said.

NATIONAL TUBERCULOSIS ASSOCIATION. T. O. Carver and Miss Frances M. Goodwin, both of Boise, represented Idaho at the National Tuberculosis Association's 47th annual meeting in Cincinnati, May 11. Miss Goodwin is executive director of the Idaho Tuberculosis Association and Dr. Carver is Idaho's representative director on the board of the national association.

Hospitalization of Mentally Ill

A completely new and modern law covering admission of mentally ill patients to hospitals was enacted by the 1951 session of the Idaho legislature. Legislation defining powers and duties of the State Hospitals Board was rewritten in harmony with the new admissions law.

The admissions law was based on language and principles of a model act drawn up by the Federal Security Administration. Original draft of the model act was prepared by a committee composed of three lawyers and five psychiatrists. Preliminary views of this committee were submitted to fifty prominent attorneys representing all parts of the country. Their suggestions were incorporated in the final draft. Final act was discussed by the committee on legislation of

Federal Council of State Governments. This committee recommended the act for passage by the various states. Idaho legislators utilized the model act making proper substitution of names and terms to conform to existing Idaho conditions.

In brief, the law provides a legal framework under which any hospital may provide for treatment of mentally ill patients who enter voluntarily or involuntarily. It is hoped that this provision will encourage community general hospitals to provide accommodations for mentally ill patients locally.

Patients may enter the hospital voluntarily under two procedures. The first requires no certificate from the referring physician and requires the head of the hospital to release the patient immediately if he seeks discharge. Second provision requires the patient to agree in advance to remain at least nine weeks. It requires that a physician recommend the admission.

Four methods of committing a mentally ill patient involuntarily are provided in the new law. First, called the standard non-judicial procedure, will no doubt be the one most widely used. This clause permits admission to any hospital on written application with which is presented certificates of two physicians. Any responsible relative may submit the written application and the certificates. Head of the hospital may then hold the patient involuntarily. Physicians are required only to state that, (a) *the patient is mentally ill*, (b) *because of his illness he is likely to injure himself or others if allowed to remain at liberty* or, (c) *is in need of care in a mental hospital and, because of his illness, lacks sufficient insight to make responsible application therefor*.

If the patient is uncooperative and will not accompany the petitioning relative to the hospital, the relative may take the petition and certificates of the physicians to the probate judge. He simply endorses action of the petition. This endorsement takes the place of a warrant for arrest. It empowers any health officer or any peace officer to take the patient into protective custody and transport him to the hospital.

If the patient objects to this action, he may do so only by demanding a judicial hearing. In this event the patient is held in protective custody in his home or in some medical facility until hearing before probate judge can be arranged.

Judicial action is based on the already executed documents, i.e., letter or petition to the head of the hospital, and the certificate of two physicians.

Hearings may be held in the patient's home, at a hospital or other medical facility. Notice of hearing may be given the patient or the testimony may be heard without the patient being present. Legal counsel to represent the patient is provided for. Evidence can be presented informally and rules of evidence suspended.

If the judge finds the person mentally ill after hearing the testimony he orders hospitalization and may do so for a temporary observational period not to exceed six months or for an indeterminate period.

Two other methods of involuntary hospitalization to meet emergencies exist.

One, called the hospitalization on medical certificate-emergency procedure, provides that any individual may be admitted to a hospital upon (a) written application by any health officer, peace officer or any other person stating it his belief that the individual is likely to cause injury to himself or others if not immediately restrained and the grounds for such belief, and (b) a similar certificate by at least one licensed physician. When endorsed by a probate judge any health officer or peace officer can act by taking the patient into protective custody and taking him to a hospital.

The other is called hospitalization without endorsement or medical certification-emergency procedure. This clause provides a framework under which any health officer, physician or peace officer who has reason to believe that, (a) an individual is mentally ill and because of his illness cannot be allowed to go unrestrained pending examination and certification by a licensed physician, or (b) an individual who has been certified under provisions of this act as likely to injure himself or others, who cannot go unrestrained pending indorsement of the certificate as provided in those sections, may take the individual into protective custody, apply for his admission to a hospital and transport him thereto. This application shall state the circumstances under which the individual was taken into custody and the reasons for the officer's belief.

The bill further provides several protective clauses to insure the humane treatment and safeguarding of the patient's rights; and specifically preserves the civil rights of a patient hospitalized. If the patient is incompetent, this fact must be established on its own merits under the provisions of existing statutes covering incompetency as a separate judicial procedure. No patient found mentally ill is ipso facto incompetent.

Idaho State Medical Association Component Societies

Beor Lake-Coribou Society	President, L. P. Gaertner Mantpelier	Secretary, E. Herran Grace
Bonner-Boundary Counties Society	President, H. Peterson Sandpoint	Secretary, H. G. Lawson Priest River
Idaho Falls Society	President, D. H. Smith Idaho Falls	Secretary, H. R. Fishback, Jr. Idaho Falls
Kootenoi County Society	President, R. T. Hensen Coeur d'Alene	Secretary, C. G. Barclay Coeur d'Alene
North Idaho District Society	President, R. W. Eastwaad Lewistan	Secretary, J. H. Bauman Lewistan
Shoshone County Society	President, L. B. Hunter Wallace	Secretary, C. I. Gibbon Kellagg
South Central District Society	President, J. W. Creed Twin Falls	Secretary, E. T. Rees Twin Falls
Southeastern District Society	President, R. B. Hegsted Pocatella	Secretary, M. M. Graves Pocatella
Southwestern District Society	President, W. B. Ross Nampa	Secretary, M. M. Burkholder Boise
Upper Snake River Valley Society	President, G. M. Jensen Driggs	Secretary, R. R. Klamt St. Anthony

**ALASKA TERRITORIAL
MEDICAL ASSOCIATION**

President, H. Romig, M.D., Anchorage


**ANNUAL MEETING
Anchorage, June, 1952**

Secretary, W. P. Blanton, M.D., Juneau

**Minutes of the Sixth Annual Meeting
of
Alaska Territorial Medical Association
May 31-June 2, 1951**

Business Meeting—May 31, 1951

The Alaska Territorial Medical Association held its annual meeting in the Elks Hall in Ketchikan, Alaska, May 31-June 2, 1951. The following members were present:

Anchorage: V. A. Cates, Milo H. Fritz, Karl F. Pelka, George G. Davis, A. L. Martin, H. G. Romig, Robert L. Smith.

Fairbanks: Hugh B. Fate, A. J. Schaible and John I. Weston.

Juneau: William P. Blanton, Grace E. Field, William M. Whitehead and John T. Clements.

Ketchikan: G. Lee Stagg, A. N. Wilson, Louis Sakazar, R. W. Carr and R. N. Hester.

Palmer: Clarence C. Bailey.

Sitka: William C. Charteris.

Wrangell: John O. Bangerman.

The minutes of the last convention which was held at McKinley Park Hotel in the fall of 1950 were read and approved.

The financial report for 1950 was read with a copy included in the records.

Dwight Cramer, president, announced that the use of the hall had been donated by the Elks and that the Elks were putting on the cocktail party and smorgasbord for the last night of the convention.

It was mentioned that a total of nine companies were exhibitors at this meeting.

It was moved, seconded and carried that the check for \$25.00 which had been received from the National Foundation for Infantile Paralysis for an exhibit be returned by the secretary with a letter of acknowledgment and thanks.

A motion was made, after discussion, that the secretary have the power to hire an assistant to help with the correspondence and books, especially with the publication of the Alaska Section of NORTHWEST MEDICINE, with a salary not to exceed \$25.00 a month.

President Cramer appointed as a committee to nominate the general practitioner of the year Milo Fritz and Arthur N. Wilson.

William Whitehead, Asa Martin and John O. Bangerman were appointed as a committee for the nomination of officers for the coming year and to suggest a location for the next convention.

Dr. Whitehead brought up the matter of the New Fisherman's Aid Act as requested by the Commissioner of Labor. After a discussion it was moved that

the secretary notify the Commissioner of Labor as follows: The Alaska Territorial Medical Association recommends that the policy of the members be to charge their regular private fees for all services rendered under the Fisherman's Aid Act. Motion seconded by G. L. Stagg and carried by unanimous vote.

The matter of the law regarding physical examinations of workers brought into the Territory was brought up. The president requested Dr. Whitehead to consult a lawyer regarding this, but the general opinion of the Association is that it is not a matter of concern to local doctors.

Dr. Stagg brought up the matter of having designated times of intermission during the meetings for the benefit of the exhibitors.

Dr. Whitehead brought up the matter of chronic long-lasting welfare cases that are considerable hardship to over-crowded hospitals.

Dr. W. C. Charteris stated that there was a waiting list for the Pioneers Home. George Davis recommended renting houses by the Territory for such cases. A motion was made and carried that the secretary inform the press that the Association went on record as favoring transporting chronic old-age cases from acute disease hospitals to enlarged facilities at Sitka or at some similar home.

Dr. Davis mentioned the case for unmarried mothers. Dr. Whitehead told about the Florence Crittenton Home. It was moved, seconded and carried that the secretary be empowered to write the Florence Crittenton Home for delinquent girls to see whether such a home could be established in the Territory.

The secretary brought before the meeting the matter of the American Academy of General Practice. A. N. Wilson, who is a member of the Academy, explained the requirements and benefits of the Academy.

Dr. Charteris extended an invitation to the Association to hold the next convention at Sitka, Alaska.

The meeting was adjourned for the day.

June 2, 1951

The meeting was called to order at 12:30 p. m.

The minutes of the meeting of May 31 were read and approved.

An invitation from Mr. Hugh Wade of the Alaska Native Service inviting the Medical Association to hold its next convention at Mt. Edgecumbe was tabled until a later date.

Dr. Whitehead talked with Mr. Ziegler, attorney, and advised the Association to take no action regarding physical examinations for incoming workers. Suggestion was tabled.

Doctor of the year committee reported:

Dr. Fritz moved that George Davis of Anchorage, Alaska, be selected as the doctor of the year. This was seconded by Dr. Martin. A unanimous vote was cast.

Committee on officers and locations reported:

Anchorage was selected as 1952 Convention City. The month of June was recommended. Moved and seconded. Unanimous vote.

Following nominations made by the committee:

President—Howard G. Romig of Anchorage

1st Vice-President—John O. Bangeman of Wrangell

2nd Vice-President—John Clements of Juneau

Secretary-Treasurer—William P. Blanton of Juneau.

Dr. Whitehead moved to close the nominations. Seconded by Dr. Martin. Unanimous vote.

Dr. Whitehead made a motion to have the secretary write letters of thanks in behalf of the Association to Dr. Cramer and other local doctors, mayor of Ketchikan, Elks Club, Fisheries Laboratory for welcome and hospitality. Dr. Cramer and Dr. Blanton to send thank you notes to all others for their kindness and hospitality. Seconded by Dr. Martin. Unanimous.

Dr. Cramer brought up the matter of doctors coming to Alaska to work in the various institutions becoming members of the Alaska Association. The decision was to stay with the by-laws as they now stand: That to be an active member in the Association the doctor must have a Territorial license. He may become an associate member by paying \$5.00 a year, but will not have voting power at the convention.

Having a T. B. clinic each year was discussed. Dr. Fritz moved that Francis Phillips, thoracic surgeon for Alaska Health Department at Seward Sanatorium, and F. L. Cottingham, thoracic surgeon, Alaska Native Service, Mt. Edgecumbe Medical Center, be invited to have a clinic again next year.

The following speakers at the 1951 convention were unanimously elected to honorary membership in the Alaska Medical Association: J. H. Crampton, Seattle, Wash.; Hugh Jones, Seattle, Wash.; Laurence Selling, Portland, Ore., and Kenneth Laundaeur, New York City, N. Y.

Motion made by Dr. Romig and seconded by Dr. Martin.

Dr. Whitehead mentioned the excellent work Dr. Jones of the Virginia Mason Hospital is doing as a pathologist for the doctors in the Territory.

Dr. Blanton told about the Territorial Committee that was appointed from Washington, D. C., as an advisory committee for the Selective Service Commission. The following are members: W. P. Blanton, chairman; C. E. Albrecht, commissioner of health, and C. L. Polley, dentist.

Local doctors should report to this committee any changes they think should be made in the classification of men for the draft.

Motion was made and seconded at 1:15 p. m. to adjourn for the year 1951.

Medical Notes

Officers elected at the annual convention of the Alaska Territorial Medical Association for 1951-52 are: President, Howard Romig, Anchorage; 1st Vice-President, J. O. Bangeman, Wrangell; 2nd Vice-President, John Clements, Juneau, and Secretary-Treasurer, Wm. Blanton, Juneau.

George Davis, Anchorage, was named General Practitioner of the Year at the annual meeting in Ketchikan.

Russell Smith of Barrow, Wisconsin, has arrived at Petersburg, Alaska, to establish his medical practice. Jesse L. Herrell and Esther B. Herrell, former Petersburg physicians, left in March for the States.

Mr. L. W. Coe, Director of the Division of Health Education, Alaska Department of Health, has been appointed to assist the secretary of the Territorial Medical Association.

Announcements of Meetings

Washington State Obstetrical Society

Annual meeting will be held at the Washington Athletic Club, Seattle, Wash., Saturday, September 8. Principal speakers will be Eakle W. Cartwright, professor of obstetrics and gynecology, University of Southern California School of Medicine, Los Angeles; Gilbert J. Vosburgh, professor of obstetrics, Western Reserve University School of Medicine, Cleveland, Ohio, and Albert W. Holman, Portland, Ore. The complete program will be published in the August issue of NORTHWEST MEDICINE.



Midsummer Seminar

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King County Academy of General Practice
Medical-Dental Bldg., New Auditorium, Seattle, Wash.
Friday, August 24, 1951, 9 a. m.

THERAPEUTIC PEARLS

Speakers:

Surgery—J. A. Duncan and Wm. B. Hutchinson

Medicine—Kyron Hines and Bruce Zimmerman

Pediatrics—S. M. Billington and R. A. Tidwell

Urology—Jack Nelson

E. E. N. T.—E. S. McElmeel

Proctology—Wm. A. McMahon

Dermatology—S. T. Parker

Orthopedics—George W. Freeman

6:15 p. m.—Informal cocktail hour and banquet at Seattle Yacht Club.

Postgraduate Courses

University of Washington School of Medicine

Neurology

August 3-4

Faculty: Norman C. Chivers, Instructor in Psychiatry; Stephen Fleck, Assistant Professor in Psychiatry; Eldon Foltz, Research Associate in Surgery; Thomas H. Holmes, Assistant Professor in Psychiatry; Robert J. Johnson, Assistant Professor of Anatomy; William K. Jordan, Assistant Professor of Medicine and Head of Division of Neurology; Louis B. Thomas, Assistant Professor of Surgery; Robert H. Williams, Professor of Medicine and Executive Officer of the Department of Medicine.

Subjects

Friday, August 3

Vascular Disease of the Brain

Diagnosis of Vascular Disease of the Brain, Anatomy of Cerebral Circulation, Physiology of Cerebral Circulation, Treatment of Acute Phase of Cerebral Vascular Accidents and Discussion of Their Prevention, Surgical Aspects of Vascular Disease of the Brain, and Rehabilitation of Patient with Vascular Disease of the Brain.

Saturday, August 4

Epilepsy

Aspects of Epilepsy, Psychological Aspects of Handling the Patient with Epilepsy, Use of Electroencephalograph in Clinical Medicine, Headache, Disease of Pituitary, Neurosyphilis, and Treatment of Parkinsonism.

Obstetrics

August 6-10

Faculty: John Clancy, Charles W. Day, Russell R. de Alvarez, James M. Dille, L. Bruce Donaldson, Marian Eberhart, B.S., Charles A. Evans, Charles S. Fine, Robert J. Johnson, Harry A. Kettering, William M. Kirby, E. Gerald Layton, Albert F. Lee, Donald M. McIntyre, Paul G. Peterson, Glen Griffith Rice, Dana Richards, Paul R. Rollins, Elizabeth Knapp Smith, Ph.D., R. Philip Smith, Alexander Stevens.

Subjects

Monday, August 6

Anatomy of Female Pelvis, Obstetric Endocrinology, Examination of Obstetric Patient, Prenatal Care, Pregnancy Diets, Anemias of Pregnancy.

Tuesday, August 7

Pregnancy Tests, Pelvimetry, Abortion, Ectopic Pregnancy, Mechanism of Labor, Obstetric Anesthesia and Analgesia, Management of Labor.

Wednesday, August 8

Postpartum Care, Water Balance in Normal Pregnancy, Toxemias of Pregnancy, Breech Presentation, Bleeding of Late Pregnancy, Postpartum Hemorrhage.

Thursday, August 9

Postpartum Infection, Use of Antibiotics, Use of Antibiotics in Obstetrics, Pharmacology of Obstetric Drugs, Medical Complications of Pregnancy, Forceps Delivery, Contracted Pelvis.

Friday, August 10

Congenital Anomalies, Biology of Viruses, Virus Diseases in Obstetrics, Use of Oxytocics, Cesarean Section, Prolonged Labor, Rooming-In.

University of Colorado Medical Center

Third annual postgraduate course on Psychiatry for the General Practitioner will be offered at the University of Colorado Medical Center July 26-28. This two and one-half-day course aims to present prevalent psychiatric concepts in general practice with emphasis on psychotherapy.

Burtrum C. Schiele, professor of psychiatry at the University of Minnesota, will be guest lecturer. Teaching staff will include twenty-four members of the faculty of University of Colorado School of Medicine.

Registration fee is \$5.00 and tuition is \$15.00. Further inquiries and applications may be made to the office of the Director of Graduate and Postgraduate Medical Education, 4200 East Ninth Ave., Denver 7, Colorado.

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SURGERY—Intensive Course in Surgical Technic, two weeks, starting July 23, August 6, August 20, September 10.

Surgical Technic, Surgical Anatomy & Clinical Surgery, four weeks, starting August 6, September 10, October 8.

Surgical Anatomy & Clinical Surgery, two weeks, starting July 23, August 20, September 24.

Basic Principles in General Surgery, two weeks, starting September 10.

Surgery of Colon & Rectum, one week, starting September 17, October 15.

Esophageal Surgery, one week, starting October 15.

Thoracic Surgery, one week, starting October 8.

Gallbladder Surgery, ten hours, starting October 22.

Breast & Thyroid Surgery, one week, starting October 1.

General Surgery, one week, starting October 1.

Fractures & Traumatic Surgery, two weeks, starting October 8.

GYNECOLOGY—Intensive Course, two weeks, starting September 24, October 22.

Vaginal Approach to Pelvic Surgery, one week, starting September 17, November 5.

OBSTETRICS—Intensive Course, two weeks, starting September 10, November 5.

MEDICINE—Intensive General Course, two weeks, starting October 1.

Gastroenterology, two weeks, starting October 15.

Electrocardiography & Heart Disease, two weeks, starting October 22.

UROLOGY—Intensive Course, two weeks, starting September 24.

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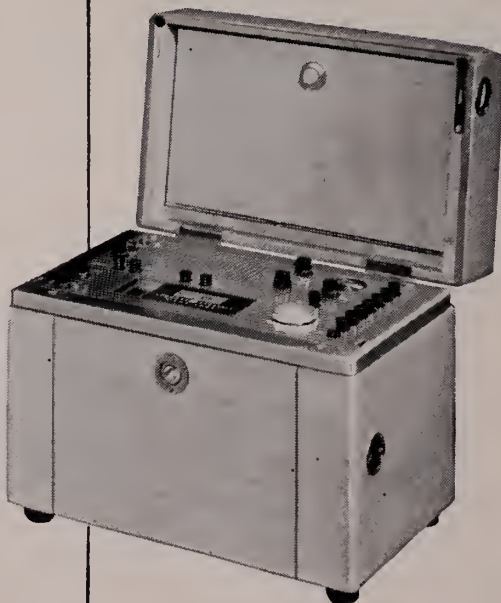
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*Fry, C. O.: J. Am. M. Women's A. 4:51 (Feb.) 1949

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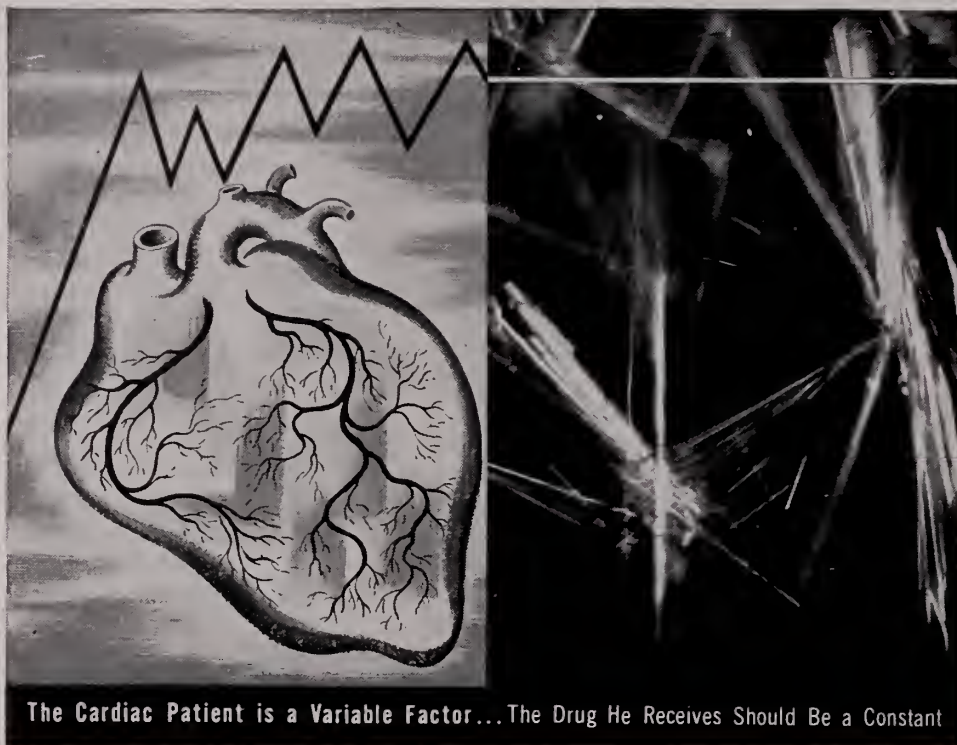
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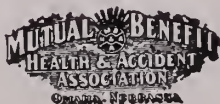
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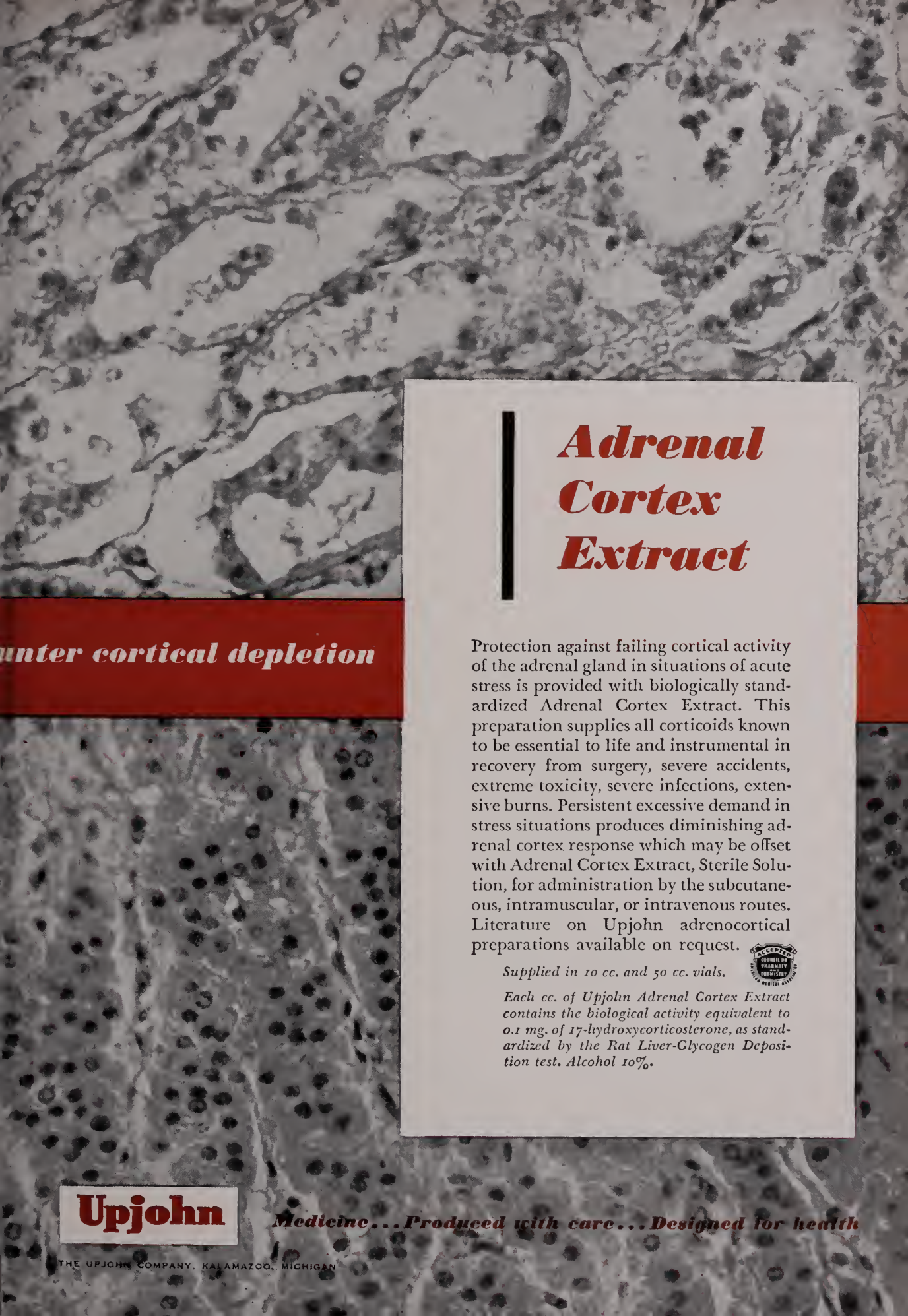
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REFERENCES: Spielman, A. D. (1950), N. Y. St. J. Med., 50:2297, Oct. 1. Brown, E. A., et al. (1950), Ann. Allergy, 8:32, Jan.-Feb. Jenkins, C. M. (1950), J. Nat. Med. Assn., 42:293, Sept. Cullick, Louise, and Ogden, H. D. (1950), South. Med. J., 43:632, July. Ehrlich, N. J., and Kaplan, M. A. (1950), Ann. Allergy, 8:682, Sept.-Oct.

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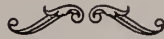
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Ontario Portland
Washington State Medical Association..... Seattle—Sept. 9-12, 1951
President, K. L. Partlow Secretary, J. W. Haviland
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Idaho State Medical Association..... Sun Valley—June 15-18, 1952
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Lewiston Boise
Alaska Territorial Medical Association..... Anchorage—June, 1952
President, H. Romig Secretary, W. P. Blanton
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- North Pacific Society of Neurology and Psychiatry**..... Seattle, 1952
President, S. N. Berens Secretary, R. A. Coen
Seattle Portland
North Pacific Pediatric Society
..... Harrison Hot Springs, B. C.—Sept. 21, 1951
President, Gordon Matthews Secretary, S. G. Babson
Vancouver, B. C. Portland
North Pacific Surgical Assn...... Vancouver, B. C., Nov. 16-17, 1951
President, S. F. Herrmann Secretary, J. A. Duncan
Tacoma Seattle

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Corvallis Corvallis
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Oregon Pathologists Association, Second Wednesday—Portland
President, V. D. Sneed Secretary, J. E. Nohlgren
Portland Portland
Oregon Radiological Society—Second Wednesday—University
Club, Portland
Secretary, C. T. Jessell
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Portland Academy of Pediatrics..... First Monday
President, S. G. Babson Secretary, Edward Rector
Portland Portland
Portland Surgical Society..... Last Tuesday
President, J. M. Roberts Secretary, J. W. Nadal
Portland Portland
Southern Oregon Medical Society..... Roseburg—May 13, 1952
President, A. M. Johnson Secretary, F. C. Adams
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WASHINGTON

- Washington State Obstetrical Society**..... Seattle—Sept. 8, 1951
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..... Third Tuesday—Seattle or Tacoma
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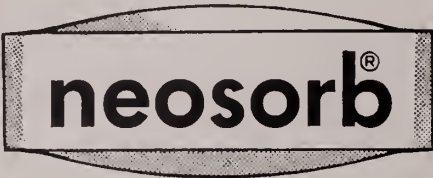
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1. Gardner, L. I.; MacLachlan, E. A.; Pick, W.; Terry, M. L., and Butler, A. M.: *Pediatrics* 5:228, 1950.

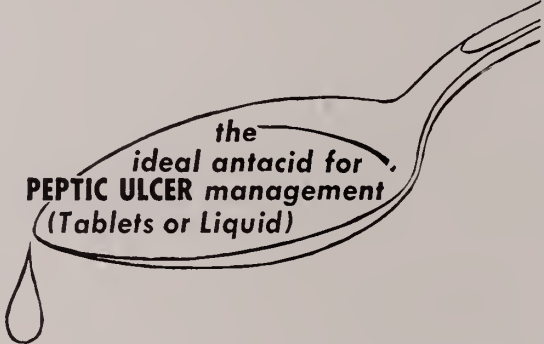
2. Nesbit, H. T.: *Texas State J. M.* 38:551, 1943.

3. May, C. D., et al.: *Bull. Univ. Minnesota Hospitals* 21:208, 1950.

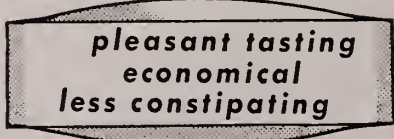
4. Recommended Daily Dietary Allowances, Rev. 1948, Food & Nutrition Board, National Research Council.



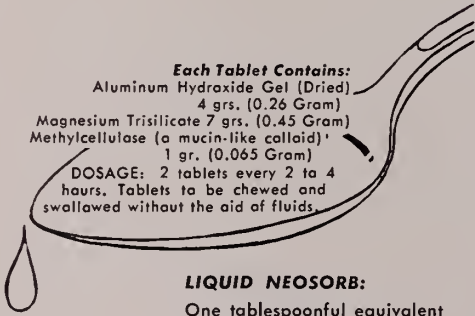
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NORTHWEST MEDICINE

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Vol. 50

AUGUST, 1951

No. 8

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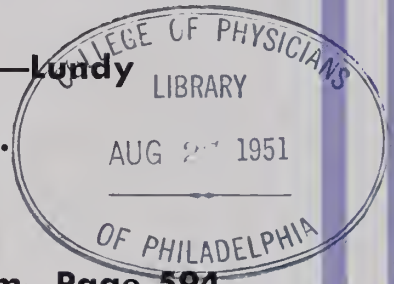
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Peristaltic Enema—Grimm

Washington State Medical Convention Program—Page 594

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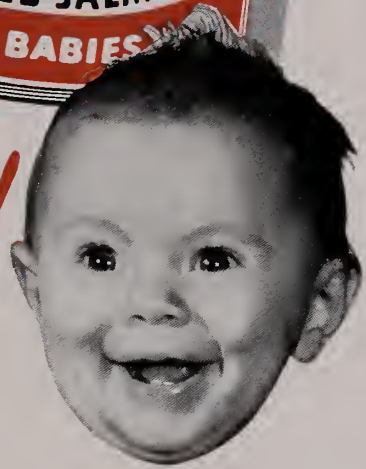
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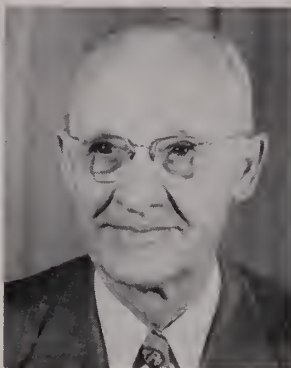
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DID YOU EVER WONDER WHERE MEDICAL TECHNOLOGISTS COME FROM? Some of them, at least, are now coming from a thorough period of training at the University of Oregon Medical School. An attractive, well-designed folder just off the press describes the course, lists pre-requisites and outlines attractiveness of the profession to prospective students. The folder carries several good photographs and some ably written copy. Sample: "If you desire to enter the field of Medical Technology, you must have a real interest in the science, must have a cooperative disposition, and moral and intellectual integrity." Those interested are requested to write the Registrar, University of Oregon Medical School, 3181 S. W. Sam Jackson Park Road, Portland 1, Oregon.



THE MEDICAL CARE DOLLAR IS SHRINKING less than the cost of living dollar, according to records of the Bureau of Labor Statistics. From June to December, 1950, the cost of living rose 5.1 per cent while costs of medical care went up only 2.3 per cent. Analysis is based on weighted figures from 18 major cities, corrected to reflect national averages. They survey medical costs every three months. Want the breakdown on who raised the most? General practitioners 1.1 per cent, specialists 1.2, drugs 2.5, hospital rates 4.9.

FAVORITE TELEVISION STORY. (It's true too) Johnny, age eight, asked permission to go down the street to watch a television show. When he returned his parents asked him what he thought about the show. He observed, "Well, the television set is nice, all right, but I'd rather live in our house than theirs." "Why is that, son?" the father asked. Johnny answered promptly, "Well, you see, we have chairs to sit on, but when they look at the television they have to sit on boxes."

BRITONS STILL CHAMPION MEDICINE GUZZLERS. Their national health service was three years old last month. Since July, 1948, their druggists have dispensed five prescriptions per year for every man, woman and child

in the country. Costs currently running at the rate of 1.3 billion dollars per annum and they still have 10,000 cases of tuberculosis waiting admission. General hospitalization is still further behind with waiting lists over 500,000. How can you call it medical care, let alone good medical care?



GEORGE LULL NEVER MISSES AN OPPORTUNITY to illuminate the antics of FSA Director, Oscar Ewing. He puts in a punch every now and then through his weekly *News Letter*. Quote—

"The Glandular Mr. Ewing." The *Sign* magazine, which recently received a gold medal as the best Catholic magazine of general circulation, recently published an interesting article about Federal Security Administrator Oscar Ewing. It was written in a popular vein and the title of the article was "The Glandular Mr. Ewing." The title evidently was prompted by the picture caption, direct quotes from Mr. Ewing: "I am not afraid of controversy. I like it. It does something to my glands."

WOMAN'S MEDICAL COLLEGE OF PENNSYLVANIA is going to considerable pains to publicize the fact that their new president will be Burgess Lee Gordon, now of Jefferson Medical College. He has had an interesting and active career, including birth at Spokane, graduation from Gonzaga and postgraduate studies in agriculture at Pullman. He received his medical degree from Jefferson in 1919. Woman's Medical College, which is more than a hundred years old, expects to embark on a fund-raising campaign to expand facilities and create new departments of industrial medicine and geriatrics. Campaign will start after Dr. Gordon assumes his duties September 1.

WISCONSIN WHACKS THE ANTIS. Governor Kohler of Wisconsin signed a new kind of bill recently which ties up the antivivisectionists rather neatly. Bill denies public funds to humane societies refusing to turn over unclaimed animals to medical schools. It also provides a penalty for such societies which refuse to comply with a 1949 law providing that they let medical schools have needed animals. Part of the controversy arose in one county in which 320 unclaimed and unwanted dogs were received by the humane society which refused to supply the 48 requested by a medical school. Strange how people are so willing to shove a poor, quivering cur into a tight box and turn on the gas. Many animals have to die that the human race may live. Few die so uselessly as those slaughtered by societies oddly called humane.

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Hamblen, E. C.: North Carolina M. J. 7:533 (Oct.) 1946.

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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol. 3:95, 1943.

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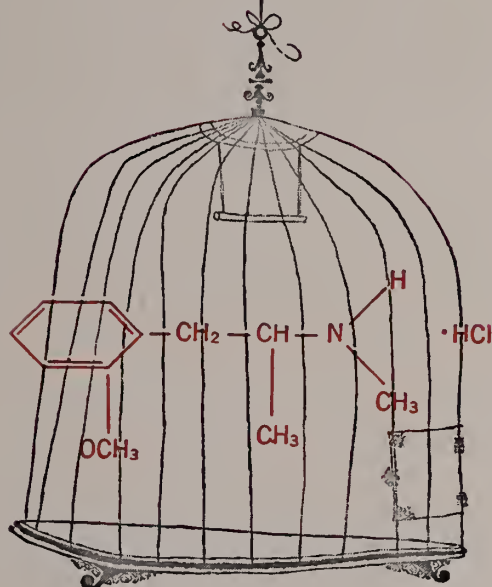
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NORTHWEST MEDICINE

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AUGUST, 1951

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EDITORIALS

Another Flank Attack

Old socializers never die. Neither do they fade away. Those who were so gleefully driving nails in the coffin of socialized medicine after the elections last fall had better take another look. Close observation of the corpse might reveal fairly regular respiration and even a glint in an eye which is quite distinctly open. Ways may be devious but the basic design never changes.

As an example, it is reliably reported that Senator Murray, chairman of the Senate Committee on Labor and Public Welfare, sent a wire to all state governors last month asking for information about over-supply or under-supply of physicians. Presumably Senator Murray is quite convinced that normal laws of competition and economic survival must be superseded by directives from Washington. This is the type of thinking which has prevailed at the capital for a good many years. It is highly uncomplimentary to the intelligence of the American people and shows the usual lack of faith of socializers in anyone who tries to do anything for himself. They can do it better from an office desk at Washington.

The telegram sent to all governors is as follows: "It has been proposed that Federal subsidies be

used to persuade doctors to move to areas where there is an acute shortage of medical personnel. Without in any way attempting to commit you regarding the merit of any such proposal, but solely to provide this committee with such information as would enable us to decide whether or not the existing situation warrants serious consideration of that or related proposals, would you please advise me as to: 1. Whether your state has too many, not enough or just about enough doctors to meet the needs of its residents; 2. Regardless of the situation characterizing your state as a whole, what cities in your state seem to have more than enough doctors to meet the needs of the people and which, as a result, would probably feel no alarm as regards the consequent shortage of physicians if special effort were made to persuade physicians now located therein to relocate elsewhere in civilian practice, to accept employment in those veterans hospitals which are now closed because of lack of professional personnel or to volunteer for service with our armed forces, public health service, or health missions abroad? It would be most useful if we could have your answer to these questions within a week."

As our friends the attorneys say—*res ipsa loquitur*—the thing speaks for itself.

Whitaker and Baxter Headline Washington Meeting

Whitaker and Baxter, fabulous husband and wife team of public relations strategists, will headline attractions planned for meeting of the Washington State Medical Association in Seattle next month. Full program and other pertinent announcements appear in this issue, starting page 594.

Tall, grey, ministerial Clem Whitaker and the ice-cool redhead, Leone Baxter, have become a unique institution in the American political scene. The singular is used advisedly. Whatever private differences of opinion they might hold are distinctly private. All public acts, ideas and statements emanate as from a single source. Witness the fact that both will appear at the Washington meeting.

This is only in conformity with their long-established custom to accept speaking engagements not as individuals but as a team.

It is quite clear that only California would have produced a Whitaker and Baxter, but by the same token it might be said that, to a certain extent, Whitaker and Baxter have produced California. Their impact upon the political scene in that state has been remarkable. Their fifteen-year record of successful influence on legislation has never elsewhere been equaled.

Emergence of Whitaker and Baxter into national prominence dates from November 27, 1948. On that date, Clem Whitaker, with deceptive hesitance in manner, but with superb dramatic skill, told

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a public relations meeting in St. Louis how California physicians defeated Governor Warren's health insurance scheme by the margin of a single legislative vote. The American Medical Association, faced with a bitter battle over the same issue, was quick to see that talents and methods of Whitaker and Baxter might well snatch victory from the then almost certain embrace of one Oscar Ewing. Results of the National Education Campaign which they put on are now quite thoroughly understood by every elected official in the land.

Methods devised by Whitaker and Baxter have made customary attempts to influence legislation

decidedly archaic. They make no attempt to influence legislators, but go directly to the voters. Thus, they display profound belief in democratic government and unflinching faith in the intelligence of the American people. Hard rock solidity of their work is well illustrated by what has happened in California.

When they helped physicians of that state defeat a health insurance plan the issue was decided by only one vote. Today no politician in California would touch such a measure. The public knows the truth and has decided. They were shown the way by Whitaker and Baxter.

Washington State Obstetrical Society

Announcement of the fall meeting of Washington State Obstetrical Society appears on page 607. The meeting is to be held just prior to meeting of the State Medical Association but is not a part of that session.

The Washington State Obstetrical Association is now about fifteen years old. Its development has been remarkable. It was first conceived as a study club type of organization and functioned thus with informal gatherings for discussion by members of

common problems. Vigor of the growth which followed is due largely to the energy and devotion of its two principal organizers, H. H. Skinner of Yakima, and P. C. Kyle of Tacoma.

The Society's influence has long since extended outside the borders of the state and its methods have developed beyond the study club stage. The twice yearly meetings have become true postgraduate assemblies with speakers and ideas coming to the northwest group from all parts of the country.

County Society vs. Hospital Staff Meetings

Compulsory hospital staff meetings are blamed by the *Journal of the Medical Society of New Jersey* for some of the poor attendance at county medical society meetings. An editorial in the July issue gives numerous reasons why the usual insistence on a perfect attendance record may be in error.

It is interesting to note that this facet of the hospital problem is engaging attention of physicians on the east coast as well as the west. It has rather recently come into focus in many sections. Actually, the long delay in recognition of dangers incident to compulsory attendance is a little hard to understand. Indeed, it is most surprising that physicians, of all people, should so submissively accept any arrangement tainted with the abhorrent word "compulsion."

"—a compulsory attendant at a meeting is not going to learn much," says the *New Jersey Journal*. "Compulsion, as we doctors love to point out, is often ineffective and inefficient, not to say almost unAmerican. Practically every doctor plays hookey now and then, and thus the hospital administrator can pull the rug out from under *any* member of the staff. Since there is no penalty for missing a county society meeting, you will miss that rather than risk disciplinary action by playing truant at a hospital session. All of which adds up to one reason for poor

attendance at county societies. We aren't sold yet on the idea that the hospital is responsible for everybody's health. We still think, some of us, that doctors have the responsibility for the practice of medicine . . . Doctors often need hospitals . . . but a doctor without a hospital makes better sense than a hospital without a doctor."

The editorial suggests that hospitals should give credit to staff members who attend county society meetings. This would permit the physician to keep pace with progress and at the same time emphasize that it is his duty, not that of the hospital, to practice good medicine.

Actually, of course, the medical society renders great service to the public (and thereby deserves public support) only when it advances the art and science of medicine. Without active and vigorous interest in education of its own members it loses its main reason for existence. Medical societies are not trade unions, interested in protection of income. They are professional societies concerned with intellectual advance. If they permit hospitals to wrest from their hands the leadership in scientific progress then indeed are they derelict in their duty—deserving respect of neither the public nor their own membership.

ORIGINAL ARTICLES

Diagnostic and Therapeutic Nerve Block in General Practice*

JOHN S. LUNDY, M.D.
ROCHESTER, MINN.

IT SEEMS timely to call attention to the value of diagnostic and therapeutic nerve block in the general practice of medicine. The effort expended in this direction is not out of proportion to the benefits to be derived from it, in some cases. There are, however, certain difficulties associated with these types of nerve block and I shall explain what they are.

Generally speaking, the acuity of diagnosis has improved very greatly in the last quarter of a century. I can testify to the fact that at the Mayo Clinic we receive some very perspicacious diagnoses when patients are referred to us from physicians who are so located that they do not have all the facilities they need to treat certain conditions. It is this very noticeable advance in diagnostic acumen that has been made generally which caused me to feel that it might be worth while to offer additional suggestions that have been utilized in my own special field, hoping that they may be of value to others outside my field.¹

INDICATIONS IN GENERAL

Among the situations in which diagnostic nerve block might be indicated are instances when, after careful physical examination, the cause of pain cannot be determined, or when the cause of pain can be recognized but cannot be either removed or cured. These generally represent the occasions on which the physician may wish to use nerve block.

ADVICE TO THE PATIENT

Interview of the patient by the person who is to do the nerve block is very important before, during and after the procedure. It should be made clear to the patient before block is done that a test is to be performed and that it is quite unlikely that any permanent benefit will accrue from it. However, the patient and the physician who is to do the block procedure must understand each other, so that questions and answers at the time anesthesia has been accomplished will establish an adequate under-

standing of the factors involved. This will enhance accurate deduction and the making of practical recommendations.

In the interview before block anesthesia is initiated, it is important to find out as much as possible about the nature of the pain, the location and duration of it, what aggravates it and also how long remissions without treatment persist. It is extremely important to know whether or not the person is addicted to the use of drugs. Generally, it has seemed that when a patient is strongly addicted to the use of narcotics, the possibilities are that he will complain that he has more pain after block anesthesia than he had before, and will say that he requires more narcotic relief after block anesthesia than before.

PSYCHIATRIC CONSULTATION

When a psychiatrist is available, it is sometimes highly desirable that he be called in consultation, for occasionally certain psychiatric patients who have pain can derive some help from diagnostic block anesthesia by the psychiatrist's developing some change in their attitude. Sometimes, in fact, the mental impact on the psychiatric patient of having his pain relieved temporarily has assisted a psychiatrist to do more for the patient than seemed likely otherwise. I do not imply that this applies generally to psychiatric patients, even those with pain, but it is something to think of in considering what may be done for such a patient.

EVALUATION OF PAIN

The interview at the time of performance of nerve block is important, because as the needle is placed, or needles are placed, and particularly if one nerve after another comes into contact directly or indirectly with the needles, certain paresthesias are produced. The physician must be sure that these paresthesias either resemble the original pain or that they do not resemble it, and the patient is the only one who can help him to determine it. In this way, the physician obtains information as to which nerves are pain paths that are important and which ones are not, in reference to block anesthesia.

USE OF ROENTGENOGRAMS

Roentgenograms which will show the location of the needles with respect to bony landmarks have

*Read at the meeting of the Idaho State Medical Association, Sun Valley, Idaho, September 6, 1950.

1. Lundy, J. S., Adams, R. C., Seldon, T. H., Pender, J. W., Faulconer, Albert, Jr., Paulson, J. A., Ridley, R. W., Osborn, J. E., and Courtin, R. F.: Annual Report for 1949 of Section on Anesthesiology, Including Data and Remarks Concerning Blood Transfusion and Use of Blood Substitutes. I. Proc. Staff Meet., Mayo Clinic, 25:553-569, Sept. 27, 1950.

become important. They impart an exactness to the technic which cannot exist otherwise. Subsequently, if it is recommended to the neurosurgeon that certain nerves be cut, roentgenograms will convince him that the nerves in question were blocked. Later, I shall illustrate this point.

INJECTION

After it has been decided that the needles have been placed properly and that not only have contacts been made with the nerves considered to be involved but also with one or two nerves above and below the involved area, injection may then be carried out. When the solution is injected under pressure, the original pain may be elicited; as the anesthesia develops, the original pain may disappear and the patient may be asked to go through those motions or to assume those positions which previously would produce the original pain or would make it worse.

RESPONSE OF THE PATIENT

Some people can give a very quick, definite answer about whether or not their pain is relieved. Others, and especially older people, cannot. They may have absorbed some of the local anesthetic agent, experienced a systemic reaction and become confused. The answer may be one of uncertainty. It then becomes very important to follow up the condition of the patient. In the period after block anesthesia has been done, after the anesthetic effect has disappeared, any systemic effect likewise has disappeared and the pain has returned, the patient may very well be positive in his answers. Only at such a time does he recognize how much relief he has obtained and it is at that time that the physician can be much more certain of the value of his patient's answers.

It is at this time, as well as during the time the anesthesia exists, an answer can be obtained as to whether or not the numbness the patient has or had is bothersome to him and whether he would mind if it became permanent, such as would happen if the nerves concerned were sectioned. A few patients say they would much prefer the pain to the numbness and they, of course, should not be operated on until they change their minds.

DIFFERENCE BETWEEN DIAGNOSTIC BLOCK AND THERAPEUTIC BLOCK

Considerable difference exists between the accuracy required for diagnostic block and the accuracy required for therapeutic block with alcohol. Needles need not be placed so accurately when a local anesthetic agent is used because more of the agent can be used. The agent usually will flood the area in question, and it is unlikely to do any harm to structures that may come into contact with the excess of solution used, over and above that which might otherwise be necessary to block a single nerve trunk.

When, on the other hand, therapeutic block with alcohol or even 6 per cent solution of phenol in water is used, I find it important to be able to check by means of roentgenograms the exact position of the needle. Injection of the solution is then carried out very slowly by what I call a "spot-wetting" technic, in which I try to wet the spot with only 0.5 cc. of the solution and to inject this quantity at ten-second intervals and also to restrict the total quantity to as small an amount as possible. Usually, 2 cc. is the smallest quantity used and 4 to 5 cc. is the largest in one spot. For some patients who experience spontaneous remission of their pain for as long as a day, it may be thought desirable to inject dolamine, which is $\frac{3}{4}$ of 1 per cent each of ammonium sulfate and benzyl alcohol, or to inject procaine hydrochloride and ammonium sulfate in various concentrations, either together or separately. I have injected as much as 10 cc. of 1 per cent solution of procaine hydrochloride without epinephrine in an attempt to block the ilio-inguinal and ilio-hypogastric nerves near the anterosuperior iliac spine. After producing paresthesias of the original pain of which the patient was complaining, I leave the needle in place and inject as much as 10 cc. of 5 per cent solution of ammonium sulfate in an effort to interrupt the ability of the nerve to conduct sensations of pain. A few patients respond to the injection of ammonium sulfate and benzyl alcohol for varying lengths of time—some, for hours to days to weeks and in a rare occasion, for months. In these cases ammonium sulfate and benzyl alcohol seem to be more effective than a local anesthetic agent, and less hazardous than the use of alcohol or phenol. Sometimes, however, attempts to treat symptoms this way can be very disappointing.

For example, for one patient who had pain apparently simulating that caused by a herniated intervertebral disk, I injected dolamine two or three times and each time the patient obtained seven or eight months' relief. After the first two or three injections, however, subsequent ones did not help her. She underwent an exploratory operation for herniated intervertebral disk and one was found. She seemed to have been unharmed by the injections. The question naturally arises as to whether she could have expected to have anyone operate on her in the first period of the symptoms caused by the herniated disk unless the evidence of the pressure of such a disk was more certain than it was at that time. However, postoperative relief lasted only a short time.

CASES IN WHICH CAUTION IS NEEDED

A patient who should arouse the physician's concern is the one who, no matter how much the fact has been impressed upon him that after a diagnostic block procedure the pain will return within two

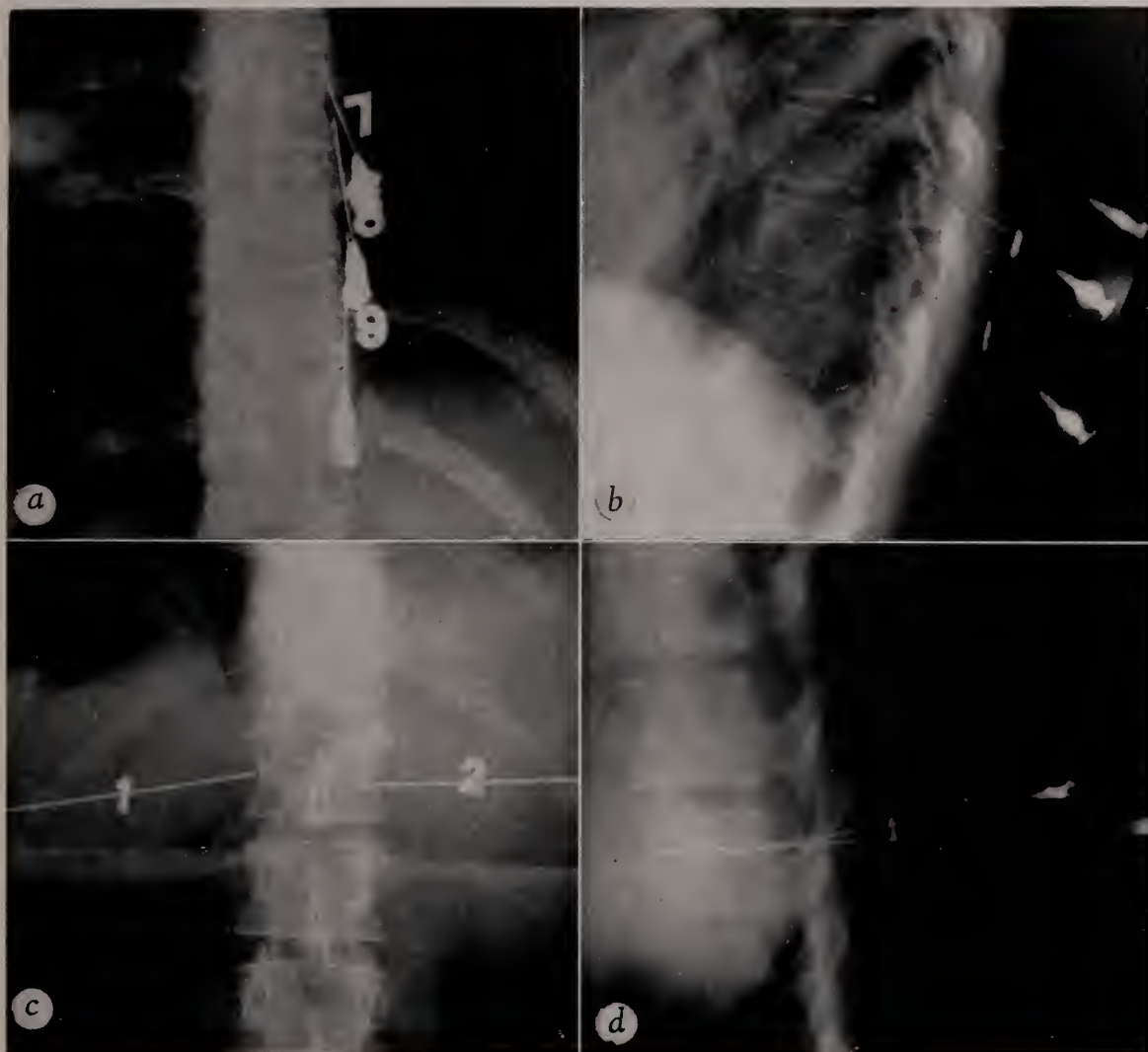


Fig. 1—*a*. Postero-anterior view of paravertebral block of right seventh, eighth and ninth thoracic nerves. *b*. Lateral view, showing top needle 7 to be short of the intravertebral foramen, middle needle 8 to be in proper place in relation to the foramen and needle 9 to be slightly higher than the intravertebral foramen but close enough for a relatively satisfactory injection. *c*. Needles properly placed on the midportion of first lumbar vertebra for block of the splanchnic nerve and celiac plexus. The lead numbers are placed on the skin where the needle perforates skin, so that the length of needle above and below the skin can be recognized. Needle 2 is on the right side (postero-anterior view). Although both needles were placed, injection was done

only through the one on the right, to see if relief was obtained. If relief had not been obtained, then injection would have been made through the one on the left side also. *d*. Lateral view. The lateral view shows one needle (needle 2 of *c*) to be placed further anterior than the other needle (needle 1 of *c*). They are both anterolateral to the body of the vertebra and injection through either one of them should give a good result. (Reproduced from Lundy, J. S., Adams, R. C., Seldon, T. H., Pender, J. W., Faulconer, Albert, Jr., and Paulson, J. A., Annual Report for 1947 of the Section on Anesthesiology, Including Data and Remarks Concerning Blood Transfusion and the Use of Blood Substitutes. I. Proc. Staff Meet., Mayo Clinic, 23:432-445, Sept. 15, 1948.

hours, is disappointed. Emphasis and re-emphasis are required, for if such a patient does not understand this point, he naturally will be very unhappy and disturbed when the pain does return, after it had been alleviated.

Still other patients will be very eager to have injections carried out for them, yet they tolerate pain very poorly. It may seem desirable not to administer an anesthetic agent or to give analgesic agents at the time, the thought being that by not doing so answers may be obtained to questions about reproduction of the original pain and relief of it. Yet, six months or a year later, when the patient perhaps wishes to avoid payment of his

account, he may refer back to his experience during the procedure and claim that it did harm to him. I am sure that many times, when the busy physician has been confronted with attacking the problem of pain, he has felt that efforts directed toward some other objective might have yielded more tangible results. On the other hand, when any of us are attacked by pain, we also become very sympathetic with the whole problem and those afflicted with it.

SPECIFIC BLOCK PROCEDURES

May I briefly illustrate some of the types of block anesthesia that have encouraged us to continue with this procedure. The purpose of one of



Fig. 2—*a*. Postero-anterior view shows silver clips placed on the right side of the first lumbar vertebra. The top clips indicate where splanchnic nerves were cut and the lower clips where the celiac plexus was resected. *b*. Lateral view of the silver clips, showing their locations at the top and bottom of first lumbar vertebra.

(Reproduced from Lundy, J. S., Adams, R. C., Seldon, T. H., Pender, J. W., Faulconer, Albert, Jr., and Paulson, J. A., Annual Report for 1947 of the Section on Anesthesiology, Including Data and Remarks Concerning Blood Transfusion and the Use of Blood Substitutes. I. Proc. Staff Meet., Mayo Clinic, 23:432-445, Sept. 15, 1948.)

them is to relieve the pain of disease of the pancreas, such as inoperable carcinoma, stones in the pancreas or acute relapsing pancreatitis. Usually, in such cases, the diagnosis is made by an exploratory operation. In most instances, needles are placed against the middle of the body of the first lumbar vertebra and dolamine injected in quantities of 10 to 20 cc. on each side. As a rule, this produces considerable relief. When the needles are placed, the original pain occasionally is aggravated, an occurrence which elicits additional information. If, then, it is determined that the patient can be relieved by a local anesthetic agent for two or three hours or by dolamine for two or three days, it often is advised that the nerves be sectioned, occasionally unilaterally only. Alcohol also can be used to effect chemical sympathectomy. At the time the nerves are cut, silver clips are placed on the nerves sectioned and roentgenograms are made. Figures 1 and 2 illustrate this.

We have obtained a rather high percentage of good results in this type of relief of the pain associated with disease of the pancreas. We have not had such results in the relief of pain associated with the gastro-intestinal or biliary system when we have used posterior splanchnic block.

Still another type of condition is the so-called arm-hand syndrome in which, for example, the patient has lost a finger or two in some accident and the hand and arm have not been used for some time because of pain on exertion. Perhaps physiotherapy has not been possible because pain in the upper extremity inhibited the patient's normal willingness to co-operate. We have seen several patients in whom alcohol block of the stellate ganglion at the first thoracic vertebra has yielded months of considerable relief in the upper extremity, with increased vascularity and, incidentally, an opportunity for the physiotherapist to carry out treatments.

In the past year at the Mayo Clinic we had an interesting experience in connection with the question of hip pain.² A little more than a year ago I carried out a block procedure of the anterior femoral cutaneous nerves of the thigh, and especially the lateral femoral cutaneous nerve of the thigh, for a patient who had pain in the hip. This man had had osteo-arthritis of the hip for many years, with disabling pain when he attempted to walk. He ob-

2. Lundy, J. S., MacCarty, C. S., and Janes, J. M.: Surgery of Femoral Cutaneous Nerves in Treatment of Disease of Hip; Preliminary Report. Proc. Staff Meet., Mayo Clinic, 25:465-467, Aug. 2, 1950.

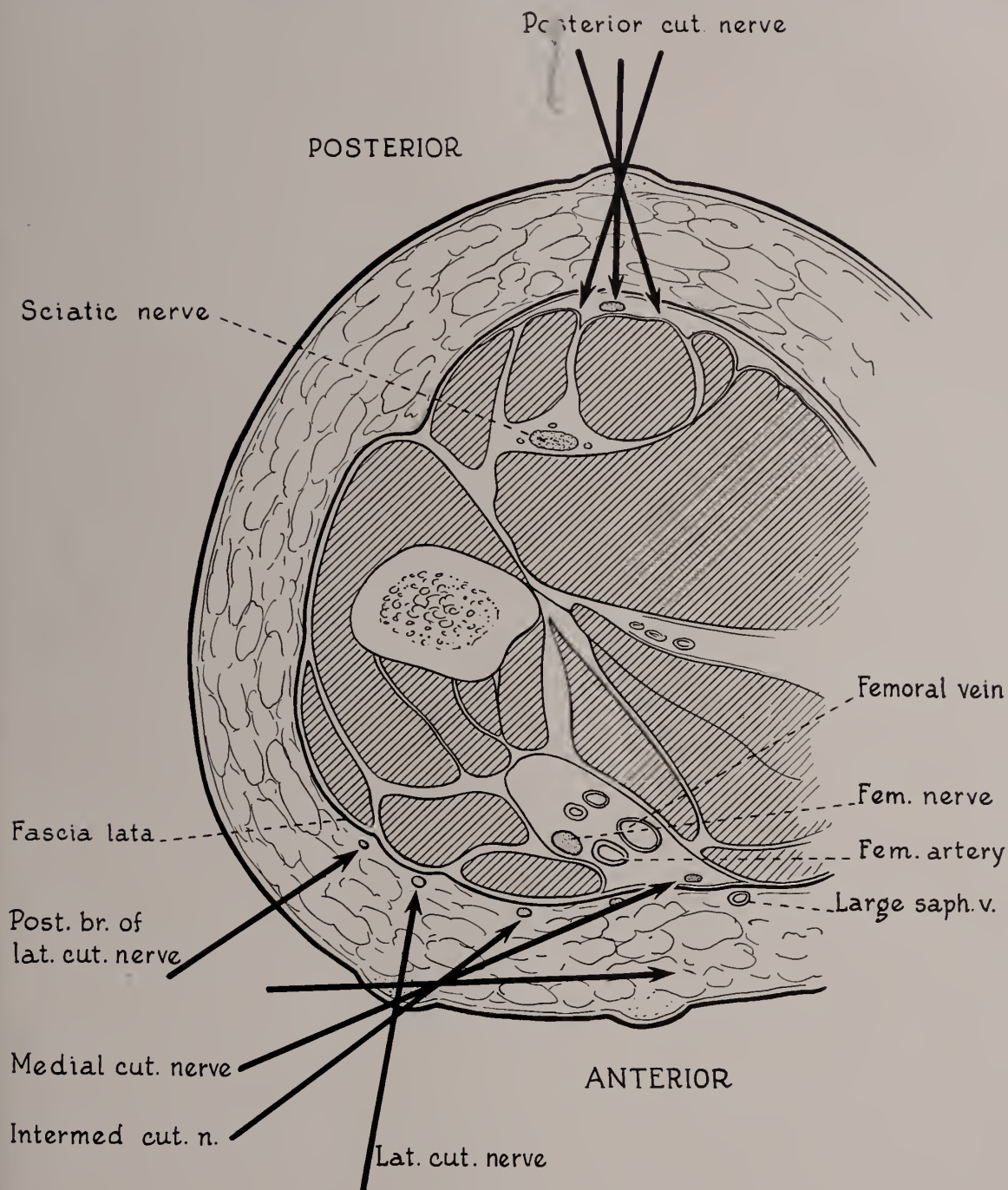


Fig. 3—Cross section of thigh to show location of the femoral cutaneous nerves.

tained so much relief from the block that he underwent operation for sectioning of the nerves that had been blocked. He has had a good year since then, with much less pain than before.

In June, 1950, I decided to try block of the posterior femoral cutaneous nerve of the thigh for a patient who had undergone bilateral sectioning of the anterior and lateral femoral cutaneous nerves of the thigh. This additional block gave him much relief from pain and so the posterior nerve was cut. The patient has been free of pain since. The diffi-

culty now lies in quite a different direction; he had had pain for so many years and was then suddenly relieved that he began to hope that it would be possible to restore motion to his fixed joints, so that he would be able to walk. It has not been easy to convince him that he is asking for the impossible. He is more than 75 years old.

In considering why patients such as the foregoing two should obtain relief of pain by block procedures, it is important to think about something other than innervation of the hip joint itself, specifically, spasm

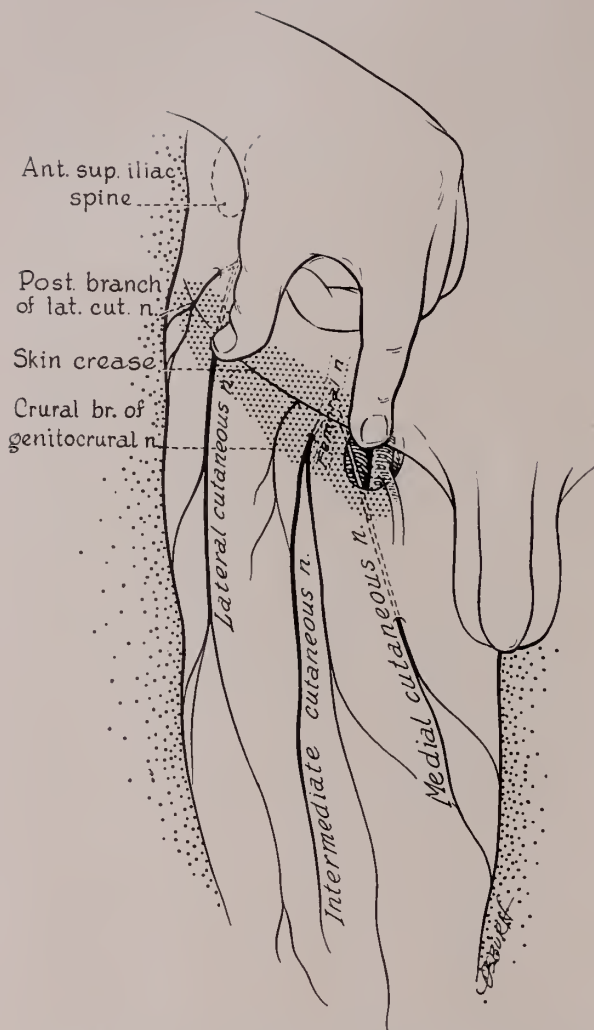


Fig. 4—Line of infiltration for blocking the anterior femoral cutaneous nerves is shown. Thirty cc. of a 1 per cent solution of procaine hydrochloride with epinephrine is used.

of the muscles in the hip and painful fascia of the hip. This in turn might lead to speculations which could, eventually, contribute to a new approach to the problem of pain and possibly a solution of it. All that is known thus far is that at least most of the patients insist that they are greatly relieved by the procedures we have discussed. Since, however, the experience has been so short and so limited, it is not possible to predict the outcome.

In carrying out the block, the physician must first be sure, before the block is done, that anesthesia is not present in the skin of the anterior surface of the thigh and that after the block has been carried out anesthesia of the skin does exist. An attempt should be made to limit the amount of anesthetic agent used and to do the block as accurately as possible. In addition, epinephrine should be added to limit the rapidity with which the local anesthetic agent is absorbed.

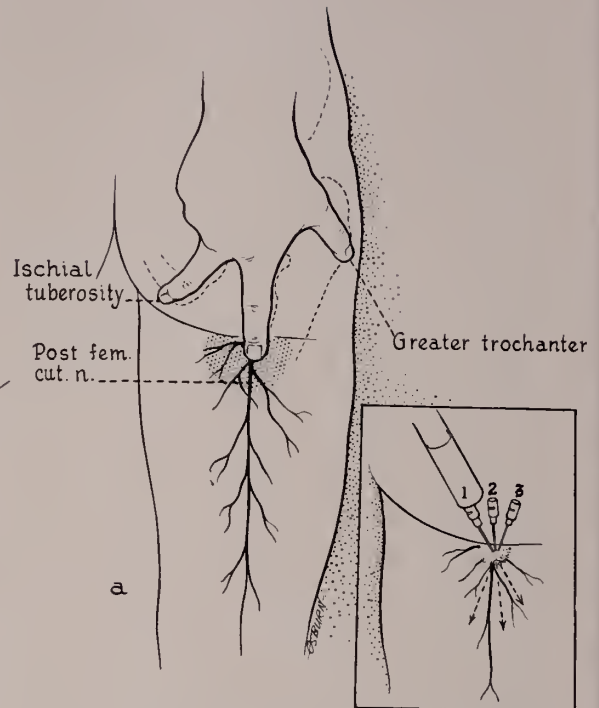


Fig. 5—Landmarks used in locating the site for injection of the posterior femoral cutaneous nerve. Ten to 20 cc. of a 1 per cent solution of procaine hydrochloride with epinephrine is used.

Parenthetically, let me recall one case in which the anesthetic agent was absorbed very rapidly. The patient had generalized arthritis and as a result of the block which I did for her hip she obtained as much relief of pain in her arm as she did in her hip, which obviously demonstrated the systemic effect of the local anesthetic agent.

The technic I have employed for injection for hip pain is shown in figures 3, 4 and 5.

COMMENT

There is a possibility for much research in this field. Methods for the determination of the effects of blocks and nerve sections on muscles and the effects of blocking nerves and nerve sections on the skin might provide data of great value concerning block procedures themselves, nerve sectioning and the possibility of nerve regeneration after nerve sectioning.

Skin resistance tests as used by Richter³ may throw additional light on this problem. Many uses for diagnostic and therapeutic blocks exist and more will be found. It is difficult to refuse to perform nerve block for some patients, in view of the fact that often it is not possible to predict whether the block will produce the desired results. Hence, nerve block must be tried, as a rule, in order actually to demonstrate what it will do.

3. Richter, C. P.: Instructions for Using Cutaneous Resistance Recorder, or "Dermometer," on Peripheral Nerve Injuries, Sympathectomies and Paravertebral Blocks. *J. Neurosurg.*, 3:181-191, May, 1946.

Mumps Myocarditis*

CAPT. M. Z. IRVIN, M.C.

TACOMA, WASH.

CAPT. T. H. BACHARACH, M.C., and ROSCOE L. PULLEN, M.D.†

NEW ORLEANS, LA.

PURPOSE of the communication is to emphasize the possible development of acute myocarditis complicating mumps and to appeal for a careful clinical study of every patient with parotid or other swelling thought to be mumps. Too frequently the convalescence of patients following apparent recovery from mumps or other acute infections is hurried and the presence of accompanying myocarditis or other systemic involvement is overlooked.

As early as 1918, Pujol¹ surmised that myocardial involvement was a complication in some cases of mumps. He observed cardiovascular abnormalities in 12 of 450 cases of mumps. All but three cases of those exhibiting circulatory disturbances were excluded because the heart disease could be explained on other etiologic grounds but objective verification of the myocardial involvement in these three cases was not available. In 1925, Barbato² also suspected the complication from his clinical observations of mumps. In 1932, Manca³ described autopsy material exhibiting an acute interstitial myocarditis attributable to the virus of mumps and which he thought was unique to this infection.

It has only been during recent years that clinical and electrocardiographic studies of patients with mumps have been forthcoming. In 1944, Wendkos and Noll⁴ reported the electrocardiographic changes of 15 soldiers convalescent from mumps. Of these random cases 6.7 per cent were complicated by myocarditis as evidenced solely by electrocardiographic methods. In January, 1943, Rosenberg⁵ observed electrocardiographically an instance of complete heart block in a patient convalescing from epidemic parotitis which, in the absence of any other etiologic factor, he considered ascribable to mumps myocarditis. Early in 1944, Rosenberg observed another patient who, during the course of mumps, developed electrocardiographic manifestations of partial heart

block which progressed to complete heart block and ultimately returned to normal. On the basis of these observations, Rosenberg⁶ undertook a systematic study of the electrocardiographic changes accompanying mumps. Sixteen of 104 patients (15.4 per cent) showed myocardial involvement, with a variety of electrocardiographic aberrations being manifested. These changes lasted four to eight days. A few persisted three to five months although complete recovery was the rule. Felknor and Pullen⁷ observed a case of mumps in 1944, combining clinical and electrocardiographic changes compatible with mumps myocarditis. This they believed to be the first case verified by both clinical and electrocardiographic observations to be reported in the literature. In 1949, Bland⁸ added an additional case to the growing literature on mumps myocarditis.

The following case is reported because it emphasizes the systemic nature of mumps infection, demonstrates the difficulty in diagnosis of the less common varieties of mumps and substantiates again the need for both clinical and electrocardiographic observations of patients with acute infections.

A twenty-seven-year-old sand-blaster was admitted to Madigan General Hospital on September 8, 1948, with chief complaints of fever, cough, shaking chills and swollen left testis. The patient had been well and working until two days prior to admission when he began to have severe chilly sensations and anorexia. On the day of admission he experienced several shaking chills and developed a moderate cough which was productive of some white sputum. The cough increased in severity and his appetite disappeared completely. At the same time he noted swelling of the left testis.

Physical examination upon admission disclosed an acutely ill, almost lethargic, moderately dehydrated white male with a temperature of 102° F. (38.8° C.). He was perspiring profusely. Examination of the head and neck was negative. Respirations were somewhat rapid and shallow. Over the lower left lung field posteriorly there were diminished breath sounds, slight diminution in resonance and some inspiratory rales. A few rales were heard over the base of the right lung on deep inspiration. Blood pressure was 100/60. Examination of the heart was normal except for rate of 120. The abdomen was flat and no organs, masses, or tender areas were felt. There was marked swelling, redness and tenderness of the left testis. The involved part could not be determined because of tenderness. By rectal examination the prostate was small, normal in size and consistency. Only a drop of

*From the Medical Service, Madigan General Hospital, Tacoma, Wash.

†Consultant in Internal Medicine, Madigan General Hospital, Tacoma, Wash.; now Professor of Graduate Medicine, Tulane University of Louisiana School of Medicine, New Orleans, La.

1. Pujol, M.: Oreillons et myocardite, *Arch. de med. et pharm. mil.* 69:527-538, 1918.

2. Barbato, M.: Un caso do parotite epidemica con complicazioni viscerali multiple, ed esito letale, *Riforma med.* 41:1109-1112, 1925.

3. Manca, C.: Miocardite du parotite epidemica, *Arch. ital. di anat. e istol. pat.* 3:707-717, 1932.

4. Wendkos, M. H., and Noll, J., Jr.: Myocarditis Caused by Epidemic Parotitis, *Am. Heart J.*, 27:414-418, 1944.

5. Rosenberg, D. H.: Acute Myocarditis in Mumps (Epidemic Parotitis), *Arch. Int. Med.* 76:257-263, 1945.

6. Rosenberg, D. H.: Electrocardiographic Changes in Epidemic Parotitis (Mumps), *Proc. Soc. Exper. Biol. & Med.*, 58:9-11, 1945.

7. Felknor, G. E., and Pullen, R. L.: Mumps Myocarditis: Review of Literature and Report of Case, *Am. Heart J.*, 31:238-241, 1946.

8. Bland, J. H.: Mumps Complicated by Myocarditis, Meningoencephalitis and Pancreatitis, *New England J. Med.*, 240:417-419, 1949.

milky prostatic fluid was obtained. This showed no bacteria or pus cells. There were large, hot, tender lymph nodes in the left groin. Neurological examination was negative except for slight stiffness of the neck and incoordination of the eyes.

Due to the patient's illness, numerous laboratory tests were performed. The white cell count on admission was 16,000, with a differential count of 74 per cent polymorphonuclear leukocytes, 25 per cent lymphocytes and 1 monocyte. The urinalysis on admission, as well as two days later, was negative except for a trace of albumen. The sputum, though scant, showed rare to moderate numbers of pneumococci. The spinal fluid studies revealed 32 cells per cubic millimeter of which 6 were polymorphonuclear leukocytes and 26 were lymphocytes. A smear of the spinal fluid was negative for any organisms and the culture showed no growth. Total protein was 16 mg. per cent. A roentgenogram of the chest taken on admission was normal. Serum amylase on September 10 was 136 mg. per cent.

About six hours after admission, the patient had a severe chill and his temperature rose to 105.2° F. (40.6° C.). Twenty-four hours after admission the right testis was swollen and tender, but less so than the left. During the early part of the hospital stay the patient was extremely toxic and required intravenous fluids, symptomatic and supportive therapy. The temperature gradually fell by lysis reaching normal by the fifth day of hospitalization. Coincident with this, the swelling of the testes rapidly receded and by the time the temperature reached normal the testes were nontender though still quite large. Improvement in well-being likewise occurred with the dissolution of the fever.

Although there were no symptoms nor findings suggestive of cardiac disease, an electrocardiogram (fig. 1) was taken on September 15 which showed inversion of T_1 , deep S_2 , inverted T waves in leads CF_1 and CF_2 . The interpretation was that of a definitely abnormal electrocardiogram, the etiology of which was not apparent. A repeat electrocardiogram (fig. 2) on September 18, showing considerable electrocardiographic improvement, was interpreted as follows:

P-R interval 0.22 seconds; rate 70. Normal axis. T_1 now upright; T_2 low. Elevated ST segments in leads CF_2 , CF_3 and CF_4 .

The patient continued to improve, and by the fifth day inflammation in both testes had subsided. Absolute bed rest was maintained for nine days following admission, at which time gradual ambulation was instituted. Further electrocardiograms were obtained on September 20 and later on October 11, which were similar to that on September 18 and were interpreted as being within normal limits. The patient was discharged from the hospital with a recommendation for another week of restricted activity at home. At the time of discharge, it was observed that the right testis had returned to normal size and consistency. The left testis was soft and it was the impression that it would eventually atrophy.

Throughout the patient's course of illness the presumptive diagnosis was viremia probably due to mumps with acute myocarditis and acute bilateral orchitis. Blood sera were submitted to the Viral Research Laboratories, United States Army, on September 18 and September 27, respectively. Joseph E. Smadel reported that both specimens were positive in very high titer for complement fixing antibodies of mumps with a two-fold rise in the second specimen. Dr. Smadel interpreted these findings as being consistent with the diagnosis of mumps.

DISCUSSION

In the absence of parotitis, the diagnosis of some of the systemic manifestations of mumps, such as meningoencephalitis, orchitis, myocarditis and the

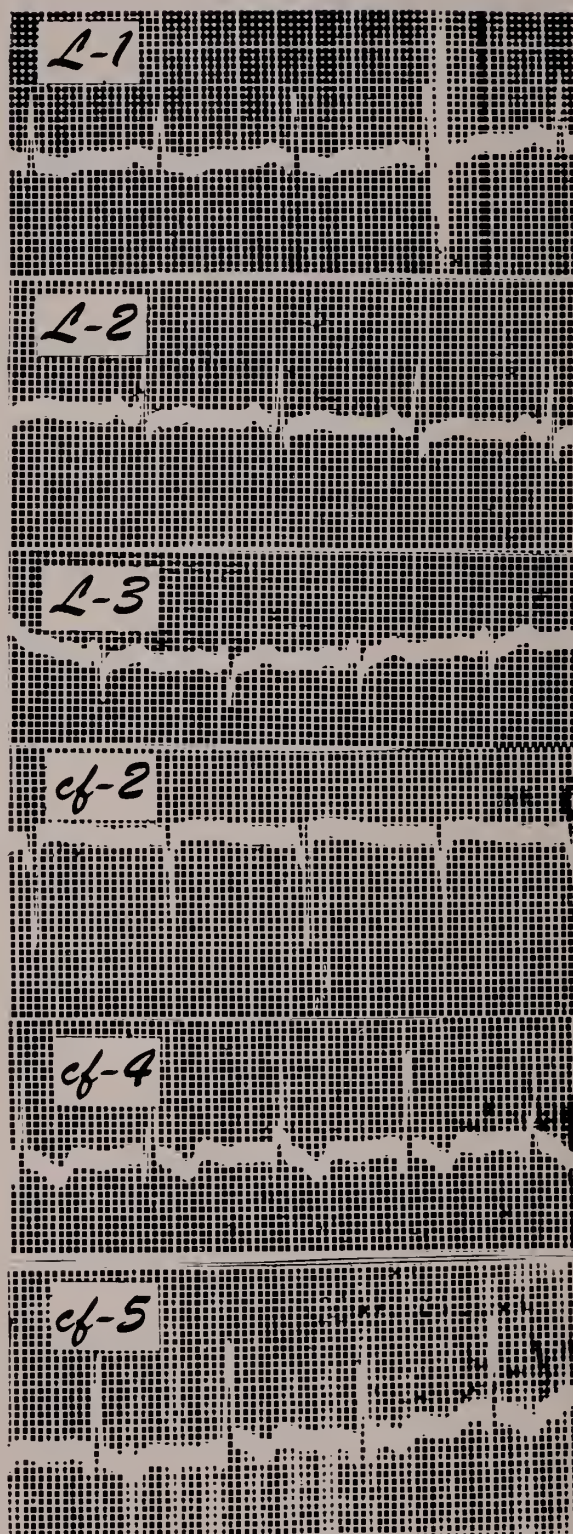


Fig. 1. Electrocardiograms of 27-year-old white man with mumps orchitis and myocardial disease. Electrocardiogram taken September 15, 1948, seven days after admission to hospital.

like, is dependent upon such tests as the complement fixation test described by Enders and Cohen^{9,10} in 1942. This reaction employs a suspension of parotid glands from monkeys infected with mumps virus. More recently, Henle and others^{11,12} have shown that mumps antigen obtained from chick embryo consists of a mixture of two serologically distinct complement fixation factors they have termed the V and S antigens. Their experience to date indicates that both antigens should probably be employed in the diagnosis of mumps in the absence of parotitis. These studies of the dual antigenicity of the mumps virus are significant in that they enlarge present concepts of viral infections. How these observations can be correlated with clinical findings is undetermined but widespread use of the complement fixation reactions will unquestionably reveal a high percentage of individuals with inapparent mumps infection. It now seems clear that the true incidence of acute myocarditis or other visceral manifestation of mumps infection cannot be stated, nor can conclusions be drawn between the severity of the illness and the development of serious systemic disease.

SUMMARY

A twenty-seven-year-old male with acute orchitis, no parotid swelling, had electrocardiographic evidence of myocarditis. Complement fixing antibodies were high. Use of this reaction will reveal cases of mumps without parotitis. Until the reaction is more widely employed the true incidence of atypical mumps cannot be stated.

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11. Henle, G., Henle, W., and Harris, S.: Serological Differentiation of Mumps Complement-Fixation Antigens, *Proc. Soc. Exper. Biol. & Med.*, 64:290-295, 1947.

12. Henle, G., Harris, S., and Henle, W.: Reactivity of Various Human Sera with Mumps Complement Fixation Antigens, *J. Exper. Med.* 88:133-147, 1948.

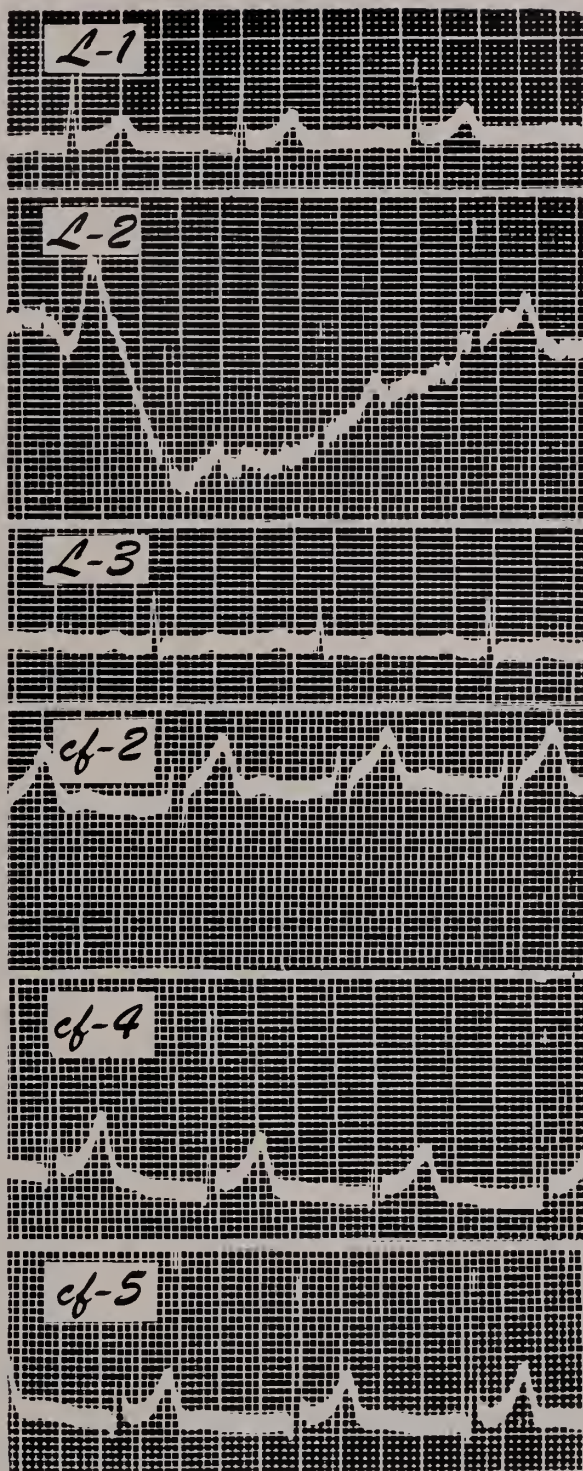
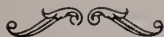


Fig. 2. Electrocardiogram taken on September 18, ten days after admission to hospital.



The Peristaltic Enema

HUBER K. GRIMM, M.D.

SEATTLE, WASH.

METHODS of cleansing the bowel were described as early as the 14th century, B. C. Although minor modifications of equipment and technic have frequently been presented, the procedure in common use today remains substantially the same as that employed many hundreds of years ago. Enemas, as commonly given, frequently result in painful intestinal cramping and little or no evacuation of the bowel. In the hope of avoiding the production of pain while simultaneously stimulating fecal elimination, Mary Ellen Stack, R.N., has devoted her entire nursing career of thirty years to the development of a method designated the peristaltic enema.

This method employs a double canister and a double lumen tube. It is called peristaltic because its chief distinction is gentle stimulation of the natural peristaltic action of the colon. In operation the flow of liquid to and from the bowel may be observed through a sight glass in one of the tubes. Such observation vividly demonstrates the action of the colon. Peristaltic waves carry the fluid from the bowel and immediately thereafter the action of reverse peristalsis takes it back into the bowel in a similar wavelike motion. The instrument is so designed and so manipulated that all this activity of the colon may take place with minimal discomfort to the patient. It is this gentle production of normal colon motility which enables the method to accomplish so much more than can be done in any other way.

Since its inception at Providence Hospital, Seattle, Wash., in June of 1950, more than 2,725 peristaltic enemas have been given to patients of all departments for an average of ten enemas per day. As it was felt that enemas should be administered by trained personnel and not relegated as a menial chore, a separate department was organized with full time devoted to enema therapeusis. These nurses, headed by Miss Stack, have given enemas so far in only those cases selected by the visiting and house staff as refractory to the usual colonic treatment, or those in which a thorough preoperative cleansing was desirable.

Achievements sought in utilization of this method have been: (1) An effort to supply water to the colon at a rate consistent with the rhythmic contractions of the intestinal canal. (2) To provide an enema as nearly free of abdominal cramping as possible. (3) To render contents of the colon more soluble to enable the patient's own expulsive forces to eliminate waste material. (4) To stimulate peris-

talsis in paralytic intestinal conditions. (5) To treat certain intestinal infections amenable to drugs by that route.

By arranging two canisters, one slightly lower than the other, and connecting them together with a suitable valve and tubing, it was found that water would enter the colon although the bottom of the supply vessel was on a mean level with the upper portion of the bowel. Frequently it was noted that when a small amount of solution, sometimes as little as one or two ounces, contacted the rectal mucosa, peristaltic activity could be observed by means of motion to and fro of the solution within a glass adapter inserted in the supply line. This in itself was not remarkable, but was felt to be so in cases wherein previous demonstrable ileus had been present.

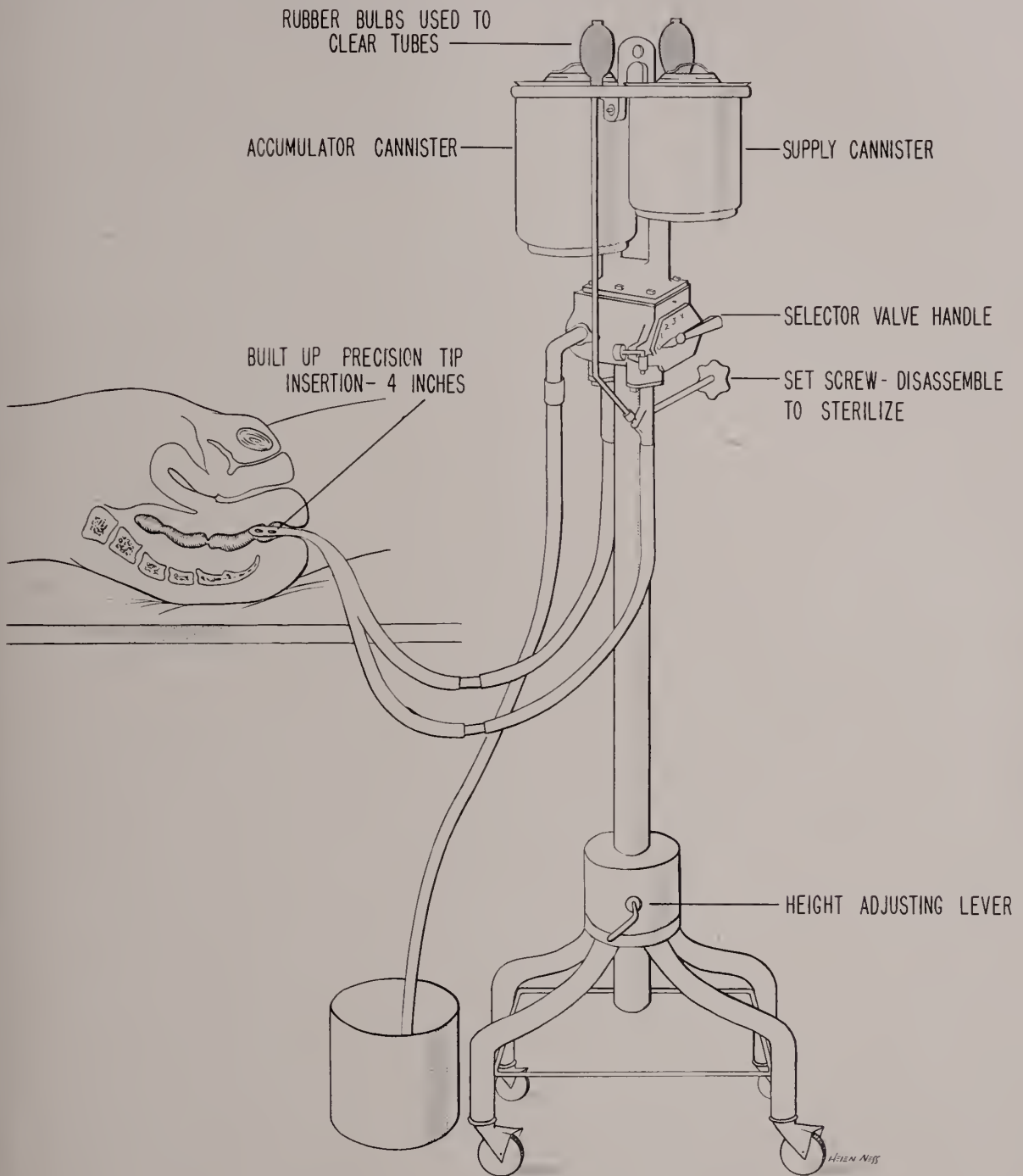
When pressure of the inflowing solution equaled intestinal pressure, no further passage of fluid occurred. To provide an escape for the colonic contents, a double lumen rectal tube was devised. This consisted of a small inflow lumen to supply water and a large outflow lumen to conduct waste contents to a receiving container. As double tubes with one inside the other would not furnish a continuous flow in both directions without creating the effect of a boiling spring, it was necessary to arrange the channels side by side in a common union. This also surmounted the difficulty of attempting to insert separate tubes within the rectal canal.

The double lumen tube was inserted a maximum distance of four to five inches and the outflow lumen connected through the valve to the connecting canister or accumulator, whose level was somewhat below the supply vessel. Such an arrangement prevented regurgitation to the supply of fresh water.

Frequently it was found desirable to increase the inflow pressure momentarily or clear the return lumen.

The selector valve control with its four positions was installed so that in position one, the supply vessel, the double lumen tube and the accumulator vessel were connected in the same circuit. This enabled liquid material to pass with ease from the colon to the accumulator during peristaltic contraction and pass from the accumulator to the colon during intestinal relaxation.

An ebb and flow was thereby established, fresh water passing as could be accommodated and soiled water likewise partially returning to the colon with relaxation. In position two, the valve was so arranged that both the return lumen and the accumu-



lators are in series with a waste can, while at the same time allowing fresh liquid to flow to the colon.

In position three, the supply was completely shut off, the return lumen and the accumulator being connected directly to the waste can.

In position four a small constrictor was inserted into the supply line limiting the flow to a drip, or to as little as five to ten drops per minute. This position was connected in series the same as in number two.

Following completion of each enema, the apparatus was easily disassembled and completely sterilized before using again.

The peristaltic enema has proven valuable in the following cases: (1) pre-operative cleansing, (2) post-operative ileus, (3) impactions, (4) megacolon, (5) diverticulosis, (6) colitis, (7) establishment of colostomy function, (8) paraplegias, with loss of bowel function, (9) following hemorrhoidectomies, (10) removal of barium following x-ray examinations.

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Possible explanation for the superiority and effectiveness of the peristaltic enema may be: (1) Basically the peristaltic enema is a return flow technic. (2) Water applied to the bowel is essentially under no head of pressure and therefore is not working against any reflexes traversing the intestine toward the anal canal. (3) A selector valve with precision ports provides a controlled variation in operation, permitting the operator to use various volumes and speeds in the flow of water applied to the bowel to fit the needs of the patient. (4) A double lumen tube so designed as to provide a definite sized inflow and outflow lumen and correct placement of the ports enables a balanced coordination between the supply canister and the accumulator. (5) Reflex stimulation of the entire colon may result from the passage of warm fluid over the rectal mucosa.

The pain factor has been a worthwhile consideration. A great majority of patients have stated it was the first time they had experienced no pain with an enema. Many patients now entering the hospital ask to have the peristaltic enema in preference to all others.

It becomes apparent from observing the peristaltic enema given in Providence Hospital during the past year that the apparatus is no magic cure for all intestinal complaints, but it does supply the skilled technician with a valuable instrument facilitating intestinal elimination. Just as the binaural stethoscope has enabled better interpretation of heart conditions as compared to the antiquated monaural, so has the peristaltic enema apparatus antiquated the clyster and water bag syringes.

Operation of the peristaltic enema is very simple and is easily mastered by the average nurse. In most cases the time limit required to bring an effective return is from 45 minutes to an hour. The amount of water or fluid used for each enema varies from 2,000 cc.s to eight ounces, depending on the patient and his condition.

In the past, the one glaring defect in the problem of intestinal elimination has been the lack of trained and interested personnel to administer enemas. The problem therefore lies in properly educating those responsible to the importance of this therapy and not delegating the enema to a position of menial duty. All too frequently, also, the bowel habits of patients are overlooked by those in attendance. Fecal impactions then ensue, producing painful consequences.

SUMMARY

1. A method of producing intestinal evacuation called the peristaltic enema is described.
2. 2,725 cases have received this procedure at Providence Hospital with a great majority of favorable results.
3. The exact mechanism by which results are obtained is not known.
4. The elimination of pain with enema administration has been greatly facilitated.
5. The greatest need is trained therapists to administer enemas in a skilled manner.
6. Closer observation of the patient's bowel habits and type of evacuation are necessary by those in attendance.



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Opinions, Views or Comments presented in articles appearing in this section are those of the individual authors and are not necessarily those of Oregon State Medical Society.

Socialized Medicine Via Hospitals Makes Official Bow

Those who kidded themselves the issue of socialized medicine was dead, as far as the current administration is concerned, can pinch themselves awake and lend support to those who opined Oscar Ewing's animal was only sleeping. For Mr. Ewing, with full administration support, including words of praise from Mr. Truman, has proposed a system of hospitalization for the aged and certain dependent groups, which in the absence of study of the bill to accomplish it, said bill now being in the process of drafting, has most of the familiar earmarks of the old socialized medicine critter, including the fleas.

As with all such propositions, the matter is dressed up to look its best and to lull the suspicious into thinking it may not amount to much. Current offer is to extend *hospital service* to all persons 65 and over and their dependents, up to sixty days in any one year, hospitals to be paid for *services*, drugs and appliances which the hospital customarily furnishes to its bed patients. Specifically excluded are *medical care except that generally furnished as an essential part of hospital bed care for patients*, and anything over ward accommodations unless patient is willing to pay for this himself.

According to Ewing, the Federal Security Administration would regard this hospitalization as the insured right of all eligibles. Since accommodations

now available could not handle the load, as the proponents readily admit, this means that additional hospital facilities will have to be appropriated for at taxpayer expense. Administration is to be by the F. S. A. preferably through delegation to state agencies, but if a state does not name an agency then any hospital in such a state could make a deal with the F. S. A. direct.

Neat trick in the proposals is to have eligibility of patients determined by a private physician. This would pass the cost of screening admissions to the medical profession, which would also collect any ill will in the matter instead of the federal bureaus involved.

Ewing proposes that cost of the project will come out of present social "security" funds not specially earmarked by congressional committees, or from an increase of about .1 per cent in current social security taxes. He claims this would lessen the current load on public welfare funds by a corresponding amount.

The plan has apparently been cooking for several months, and at a press conference Ewing admitted he had consultations with labor leaders and officials of the American Hospital Association and the Catholic Hospital Association, as well as numerous Senators, Congressmen and administration faithfuls.

Ewing was careful to point out that although he conferred with representatives of the named hospital associations he would not say these groups supported the idea. But as yet, the writer has not had called to his attention any denouncement of the scheme from responsible hospital sources, although it is possible these may be in the making.

Crowning propaganda touch designed to put the doctors on the defensive in advance was contained in Ewing's reply to the question of possible opposition.

"I can't conceive of anyone with a heart opposing this," was the substance of his words. "This is something they will have paid for themselves in insurance. I can't believe doctors don't want sick people to have attention."

Although the hospitals may not yet realize it, this could well be their acid test in relation to socialized medicine. It will be interesting to watch how they react to Ewing's proposals.

National Blue Shield Service, Inc., Gets License

A license authorizing National Blue Shield Service, Inc. to transact business was issued by the department of insurance in Ohio on May 22, 1951. This means that the national "enrollment" agency set up by the Blue Shield plans, and which turned out to be the insurance company which the A. M. A. at one time said it didn't want, is now officially in business.

Oregon, Washington and Idaho do not have any stock in the Blue Shield insurance company, but all three states may in the future possibly be affected by the operations of this concern. Oregon prepaid plans are members of the Blue Shield Medical Care Plans, Inc., the parent organization for the national insurance company, but did not approve of the venture and did not subscribe to any capital stock. Washington and Idaho plans are not members of the association of Blue Shield plans. Other state plans not subscribing to the capital stock structure include Utah and New Jersey, both of which joined Oregon in opposing the venture on basic principles when it was first considered.

A bulletin from Mr. Frank E. Smith, director of the Blue Shield Association, contains the following additional information about the new doctor-sponsored insurance company:

Home Office—the home office of National Blue Shield Service, Inc., has been established in the Beggs Building, 21 East State Street, Columbus, Ohio (also home office of Ohio Medical Indemnity, Inc., the Blue Shield Plan in Ohio).

Board of Directors—the following were elected by the shareholders as members of the Board of Directors:

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 Frank Van Holte, *Assistant Secretary-Treasurer*

Executive Committee—the following were elected by the Board of Directors as members of the Executive Committee:

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Paul R. Hawley, M.D.	Charles H. Coghlan
R. L. Novy, M.D.	W. M. Bowman

Legal Counsel—Howard Hassard has been retained as Legal Counsel by the corporation. Mr. Hassard is a member of the firm of Peart, Baraty and Hassard, San Francisco, and is also Legal Counsel for Blue Shield Medical Care Plans.

Administration—Jay C. Ketchum, Detroit, has been appointed by the Board of Directors to serve as Executive Vice-President, and Charles H. Coghlan, Columbus, has been appointed to serve as Resident Vice-President. Arrangements were made by the Board of Directors with Michigan Medical Service and Ohio Medical Indemnity, respectively, whereby Messrs. Ketchum and Coghlan will receive no direct salary from NBSS but the Plans involved will be reimbursed for any time spent by their respective Executives while engaged in behalf of NBSS. The amount of



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such reimbursement was set at a rate in proportion to the salaries being paid by the Plans to Messrs. Ketchum and Coghlan.

In accordance with a previous agreement between the Blue Shield and Blue Cross Commissions, regarding administration of the two insurance companies, the appointment of Messrs. Ketchum and Coghlan, as noted above, was reported to a meeting of the Joint Executive Committee of both Commissions in Biloxi, and the appointments were agreed upon as being "mutually satisfactory."

Next Steps—Applications for licenses are being prepared for filing in several states, and Blue Shield Plans will be advised as soon as any such licenses are issued.

Mr. Ketchum has been authorized to negotiate with Health Service, Inc., regarding a joint operating agreement, the terms of which will be referred to the Board of Directors for approval.

Mr. Ketchum has also been requested to discuss with the Blue Cross Commission and/or Health Service, Inc., the program of health care to be undertaken by the Department of Defense for the dependents of military personnel, and to make it known that Blue Shield desires to participate and provide the medical care benefits if such a program is established.

O. P. S. Directors Recommend Study

At its regular June meeting the board of directors of Oregon Physicians' Service authorized the undertaking of an analytical survey, to supplement the study made some four years ago, by McKinsey and Company, of San Francisco.

The authorization was forwarded to the Council of the Oregon State Medical Society in the form of a resolution recommending the study be made by "an independent firm of business and management counsellors selected by a committee of the Society and the Board of Directors jointly, but under the direction of this committee, at the expense of O. P. S." The recommendation was accepted by the Council at its July meeting.

The Society committee referred to is the committee of twelve under the chairmanship of J. D. Rankin, Coquille, named to study the one-package proposal of O. P. S. Current plan is to have the analytical study made by a subcommittee of four, the findings submitted to the entire committee, and any recommendations adopted will be reported to the state Council.

The subcommittee is headed by Russel Kauffman, Portland. Other members are Blair Holcomb, Portland; Frank Fowler, Astoria, and Morris Crothers, of Salem.

Pete the Pest Says

Band Wagon Jumper? Minnesota Medical Service plays with different rules than Oregon when it comes to national Blue Shield "enrollment" insurance company. Oregon sez the conception is wrong, also palavering with Blue Cross for "joint" handling, wants none of set-up and doesn't kick into capital stock kitty. Minnesota, which goes along with Oregon in some matters, apparently sez maybe. Waits until National Blue Shield Service (wanna bet you won't be wondering what NBSS stands for?) gets its official charter last December 5th, 1950, then kicks in with contribution of \$7,500. Must be canny Scot at Minnesota helm, but Oregon gets palm for stand on principle.

Note: Minnesota "giftie" raised total kitty for NBSS to \$382,519.

* * *

Getting His Number: Medico in upstate town some months ago acquired two-doors-away medical neighbor recently come to town. Like good neighbor paid his respects, also had wife call on colleague's hausfrau. Wasn't surprised when newcomer called him in on

1950 - 1951

Oregon State Medical Society

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couple of cases, but didn't make initial call with eye to business. Obligated colleague in consultations but somehow wasn't happy about relationship, though not able to put finger on what seemed wrong. Talked about thing one evening to his wife who then admitted similar indefinite feeling about newcomer's wife. Both tried to figger it out. No luck. Until little incident solved it.

For no understandable reason new doc's wife took to parking extra car across street from old doc's residence, though warned by neighbors it was dangerous corner account of being on curve which drunk drivers had trouble rounding.

One day parked directly across from old doc's driveway. Latter's young son despite caution in backing from garage eased family car into newcomer's buggy. Son immediately called dad, who forthwith called new doc to say he would stand repair bill, since he was legally responsible, new doc's car being parked. But also expressed regret new doc's wife had seen fit to park car there on dangerous curve. New doc agreed it was probably dumb thing to do but said wife picked spot so new car wouldn't get dripped on by trees.

Old doc arranged for repairs, and paid bill, now figgers he knows what's wrong with new neighbors. Although not *legally* responsible for any damage to their car, he claims good neighbors under circumstances (through funny parking) would have offered to pay part of bill, an offer which wouldn't have been accepted, but absence of which was tip-off.

Now old doc is "too busy" to give younger doc a boost he might be able to use. Tsk, Tsk, doc, Should you judge people by your own code of living?

* * *

No takers: Portland oldtime doc is having himself a field day kidding medical friends and former associates following July publicity exposures of chiropractors running abortion mills. Wants to know which one of them *wasn't* offered chance by former owner to buy long notorious, ultra-swanky "parlors" involved in racket so they wouldn't have to be sold to a naturopath!

* * *

Shysters' Holiday: Portland medicos frequently meeting at lunch roundtable had new topic when metropolitan press featured arrest of numerous chiropractors on charge of manslaughter-abortioning. Most were loud in praise of D. A. office which could plan and conduct raids without leaks. But all dourly skeptical convictions would follow. The skeptical figure chiropractors count on reluctance of witnesses to testify, plus loopholes in chiropractic and medical practice acts which defense lawyers can turn to good advantage. One doc has offered ten to one bets against convictions, proceeds win or lose to go to Red Cross. No takers at press time.

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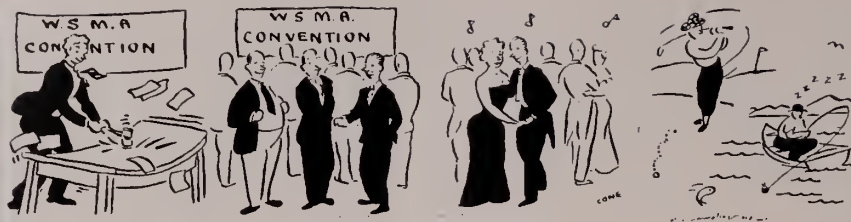
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62nd ANNUAL

CONVENTION

Olympic Hotel, Seattle, September 9-12, 1951

HIGH INTEREST IN WASHINGTON STATE MEDICAL ASSOCIATION CONVENTION



LEONE BAXTER

General Manager, National Education Campaign, A. M. A.

AN indication of the members' high interest in the September Annual Convention of the Washington State Medical Association is the large hotel registration. Convention dates are September 9-12.

Two months prior to the opening date of the Annual Sessions, hotel registration showed a substantial increase over the first day of the Convention two years ago, when it also was held in Seattle.

This high interest is well founded, because every detail of the program points toward success.

The Scientific Program, on Tuesday and Wednesday, Sept. 11 and 12, according to Fred J. Jarvis, chairman, is broad enough to intrigue every member who attends, no matter what his special interest might be. A tentative agenda is carried elsewhere.

Applications to Fred E. Cleveland, chairman of scientific exhibits, indicate all space will be filled with a wide assortment of scientific displays. All space for technical exhibits has been engaged for months. A list of exhibitors will be found elsewhere in this issue.

Arrangements for the Salmon Fishing Derby and the Physicians Golf Tournament on Monday are going forward, with assurance of hot contests in both events. Edmund Smith, chairman of the Fishing Derby, is making elaborate plans which guarantee every angler a good time.

D. H. Houston, president of the Washington State Golfers Association, has engaged the Seattle Golf and Country course again. The course has undergone extensive changes in preparation for the U. S. Open Tournament to be held there next year.

Pre-convention meetings start on Saturday, Sept. 8, with the Finance and Medical Defense Committees scheduled to confer in the morning and the Board of Trustees meeting in the afternoon.

President Kenneth L. Partlow's dinner for the Board of Trustees and Scientific Works Committee will be held at the Washington Athletic Club on Saturday evening. This is a stag affair.

CONVENTION BULLETIN BOARD

For hotel reservation use blank printed on page 605. "Care and Treatment of Fishpox (salmon variety)", page 602, recommended reading for all who plan to attend convention.

Hobby Shaw information on page 601.

Golf and fishing prizes will be awarded at sports dinner, 6:30 p. m., Monday, September 10, Seattle Golf Club.

For list of exponents of private enterprise, see page 600. Rhadamel selected.

Scientific Sessions start Tuesday and Wednesday at 9:00 a. m.

For information not contained in program see Fred J. Jarvis or Mr. Ralph Neill, 328 White-Henry-Stuart Bldg., Seattle.

First session of the House of Delegates, with M. Shelby Jared presiding, will be held at 2 p. m., Sunday, Sept. 9.

President Partlow will deliver his presidential address between 11 a. m. and 12 noon on Tuesday, preceded by a talk by Mr. John McClelland, Jr., Longview newspaper editor, on "Better Working Relationship Between the Medical and Journalism Professions."



CLEM WHITAKER

Director, National Education Campaign, A. M. A.

The big break in Convention routine comes on Tuesday evening, Sept. 11, when the Annual Banquet and Dance will be held at the Olympic Hotel, convention headquarters. The hostelry broke precedence by closing the beautiful Georgian Room to the public for this convention affair. Dress is optional.

The Public Relations buffet luncheon, for physicians and their wives, will take place Wednesday noon, with Clem Whitaker and Leone Baxter, public relations counsel for A.M.A., as the speakers of the day. This luncheon will be followed by the final session of the House of Delegates, installation of R. A. Benson of Bremerton as the new president and the annual election of officers.

Climax of the Annual Meeting occurs on Wednesday evening, with the reception for the newly inaugurated president.

KENNETH L. PARTLOW*President***Washington State
Medical Association****1950-1951****PRESIDENT'S MESSAGE**

to

SIXTY-SECOND ANNUAL CONVENTION**Seattle, September 9-12, 1951**

WASHINGTON STATE MEDICAL ASSOCIATION Conventions are just what the membership makes them. Your attendance and active interest in all proceedings are the most important factors in making the annual sessions what they should be. I therefore urge you to bring your wives to your annual meeting in Seattle, on September 9-12, inclusive.

Convention committees have been working steadily for the past several months in preparing programs that will have appeal to every section of the profession, and only attendance in goodly numbers is needed to make the meetings a complete success.

Care has been taken not to crowd the scientific sessions to the point of boredom. In other words, full opportunity exists for a sports program of Golf and Fishing, the Annual Banquet and Dance, for visiting scientific and technical exhibits and for fraternizing with former schoolmates and just plain office talk with your fellow practitioner.

The House of Delegates' sessions are always interesting and should receive your undivided attention. Through the House, the voice of the membership is heard. There is where attempts are made to solve our over-all problems.

Public Relations is always a popular subject, and extra emphasis has been placed on the Wednesday noon luncheon, when Whitaker & Baxter, A. M. A.'s public information team, will give us the latest developments from a nation-wide viewpoint.

The Auxiliary will hear reports on the Atlantic City Convention from Mrs. R. M. Schulte and Mrs. A. J. Bowles, president and president-elect respectively of the Woman's Auxiliary to the Washington State Medical Association.

You can't afford to miss the Convention, and you will be most welcome.

Sincerely,

KENNETH L. PARTLOW, President
Washington State Medical Association

SCIENTIFIC PROGRAM
(Tentative)
SIXTY-SECOND ANNUAL CONVENTION
WASHINGTON STATE MEDICAL ASSOCIATION
Tuesday, September 11, 1951

Morning

General Scientific Session

OLYMPIC BOWL

Arthur E. Lien, M.D., Presiding



FRED J. JARVIS, M.D.
Seattle, Chairman,
Scientific Program

- 9:00 Abacterial Pyuria
(Speaker to be selected.)
- 9:20 Hormone Therapy
in Management of
the Patient with
Functional Uterine
Bleeding (speaker
to be selected).
- 9:40 Recognition and
Treatment of Early
Carcinoma of the
Cervix, Simeon T.
Cantril, M.D., Se-
attle.
- 10:00 Diagnosis, Treat-
ment and Etiologi-
cal Factors in En-
dometriosis, Edw.
Allen, M.D., Chi-
cago.

**Section on Ophthalmology and
Otolaryngology**

JUNIOR BALLROOM

Clifford E. Benson, M.D., Presiding

- 9:00 Nasal Physiology in Its Relationship to
Common Nasal Disorders
George Drumheller, M.D., Everett
- 9:30 Acute Respiratory Diseases in Children
John Carney, M.D., Seattle
- 9:40 Labyrinthotomy of Meniere's Disease
Malcolm N. Wilmes, Tacoma
- 10:00 SYMPOSIUM—
DISEASES OF OCULAR FUNDUS
John F. Tolan, M.D., Moderator
Congenital Developmental Lesions
Andrew DeRoeth, M.D., New York City
Lesions Local to the Fundus
C. W. F. Jensen, M.D., Seattle
Fundus Lesion in General Diseases
W. T. Hasler, M.D., Everett
This Symposium is in commemoration
of the 100th Anniversary of Helmholtz'
Discovery of the Ophthalmoscope.
(General Men Are Especially Invited)

Afternoon

General Scientific Session

OLYMPIC BOWL

Kenneth L. Partlow, M.D., Presiding

- 2:40 Practical Aspects of Treatment of Headache,
Stewart G. Wolff, M.D., New York
- 4:00 SYMPOSIUM ON ALCOHOLISM
Moderator to be selected
Chemical Testing Procedures, T. A. Loomis,
M.D., Seattle
Conditioned Reflex Treatment, W. Voegtlin,
M.D., Seattle
Psychotherapy, Stephen Fleck, M.D., Seattle

Section on Pathology

JUNIOR BALLROOM

David Mason, M.D., Presiding

- 2:40 Progress Report on
Washington State
Tumor Registry,
H. Davis Chipps,
M.D., Seattle
- 3:00 Use of Flame Pho-
tometer and Polar-
agraph in the Clin-
ical Laboratory,
Hugh W. Jones,
M.D., Seattle
- 3:20 Medical Technician
Training Program
at the University
of Washington, W.
Lippincott, M.D.,
Seattle
- 3:40 Advantages of the
Medical Examiner
System Over the
Coroner's System,
Charles Larson,
M.D., Tacoma
- 4:00 Useful Laboratory Procedures That May Be
Performed in the Doctor's Office
Emmanuel Bitar, M.D., Everett



**EDWARD ALLEN, S.B., M.D.,
F.A.C.S.**

Clinical Professor of Obstetrics
and Gynecology, University of
Illinois; Chairman and Attending
Obstetrician and Gynecologist,
Presbyterian Hospital, Chicago,
Illinois.

KELLEY-ROSS
Prescription Pharmacy

Joins in extending a hearty welcome
to the Delegates to the W. S. M. A.
and their wives and friends.

MEDICAL-DENTAL BUILDING
SEATTLE, WASHINGTON MAin 3565

Greetings to Biddle & Crowther, 321 Seneca St., Seattle—"Everything Surgical"—on the occasion of the observance of their Silver Anniversary. They started on Broadway at the corner of Madison and moved to their present location in 1931. Widely

known for their adherence to good merchandising and good service they have friends in every corner of the world. At last call they were preparing shipment of surgical instruments to Pakistan. R. G. Biddle heads a staff of seven.

SCIENTIFIC PROGRAM*(Tentative—Continued)***62nd Annual Convention****Washington State Medical Association****Wednesday, September 12, 1951****Morning****General Scientific Session****OLYMPIC BOWL****R. A. Benson, M.D., Presiding**

R. A. BENSON, M. D.
Bremerton, President-Elect,
W. S. M. A.

Bremerton will have its first president of the Washington State Medical Association when Reuben A. Benson is inaugurated on September 12, succeeding K. L. Partlow of Olympia. Dr. Benson is a member of the Executive Committee and Board of Trustees, and is Chairman of the Advisory Committee to the State Department of Health.

- 9:00 Therapeutic Nuggets The Frozen Shoulder, William Duncan, M.D., Seattle
Dramamine in Treatment of Postoperative Vomiting, (Speaker to be selected)
Milk Allergy in Infants, Norman W. Clein, Seattle
Intravenous Procaine, (Speaker to be selected)
Stellate Ganglion Block in Treatment of Cerebrovascular Accidents, (Speaker to be selected)
Management of Treatment of Intermittent Claudication, Charles F. MacMahon, Seattle
Present Status of Use of Anticoagulants in Treatment of Intravascular Clot (Speaker to be selected)

10:40 VISIT EXHIBITS

11:00 Use of Antibiotics in Treatment of Tuberculosis, Robert Davies, M.D., Seattle.

(Second paper by Dr. Wolff of New York)

Afternoon**Forum on Fundamental Problems****JUNIOR BALLROOM James W. Haviland, M.D., Presiding**

- 2:40 Treatment of Arteriosclerosis by the Catecholizing Hypotrophic Agents, A. Nelson, M.D., Seattle
3:00 Treatment of Acute Rheumatic Fever by Cortisone and ACTH, William M. Kirby, M.D., Seattle
3:20 Work Capacity in Patients Convalescing from Rheumatic Fever, R. A. Bruce, M.D., Seattle
3:40 Clinical Study of the Effect of Several Sympatholytic Agents and Parasympatholytic Agents in Bladder Function, D. E. MacDonald, M.D., Seattle
4:00 Cocksackie Virus and the Hoquiam Epidemic Pleurodynia Outbreak, L. E. Powers, M.D., Seattle
4:20 Life Situations—Emotional Reactions and Urinary Excretion of the 17 Ketosteroids, H. S. Ripley, M.D., Seattle
4:40 Experiences with Use of Various Fluids Intraperitoneally as a Mechanism in Prevention of Reformation of Intestinal Adhesions in Rats and Dogs, L. B. Kiriluck, M.D., and A. A. Merendino, M.D., Seattle

Section on General Practice**JUNIOR BALLROOM****Presiding Officer to Be Selected**

- 9:00 Audience Reaction to Family Life Education Talks, E. R. White, M.D., Spokane
9:20 Tonsil Anaesthetic (Speaker to be selected)
9:40 Some Pitfalls in Management of Common Fractures, C. MacArthur, M.D., Olympia
10:00 Office Detection and Diagnosis of Cancer E. Rawson, M.D., Seattle
10:20 Bedside Cardiology—Recognition and Management of Cardiac Conditions Without Aid of the Laboratory, C. E. Watts, M.D., Seattle
10:40 VISIT EXHIBITS
11:00 SYMPOSIUM—
PSYCHIATRY IN EVERYDAY PRACTICE
Moderator to be selected
Functional Organic Complaints
Edwin G. Bannick, M.D., Seattle
Mild Depressive, F. E. Lemere, Seattle
Indications For and Against Psychiatric Referral (Speaker to be selected)

Haviland Compiling Enviably Record

Dr. James W. Haviland of Seattle is completing his third year as Secretary-Treasurer of the Washington State Medical Association. Previous to his election to this post, he served one year as assistant secretary-treasurer.

By virtue of his present office, one of the most responsible in the State Association, Dr. Haviland is a member of the Board of Trustees, the Executive Committee and is secretary of the Committee on Medical Defense. He is Associate Editor of NORTHWEST MEDICINE.

Dr. Haviland also is Assistant Dean of the School of Medicine, University of Washington.

As secretary-treasurer, Dr. Haviland is responsible for the recording of proceedings of the general meetings of the Association and of the meetings of the House of Delegates, Board of Trustees and the Executive Committee. He is custodian of all records and Association property and carries on all official correspondence. He represents the Association at committee hearings during State Legislative sessions.

He assists the Finance Committee in drawing up the Association's annual financial budget, signs checks and keeps a tight rein on expenditures.

In carrying on all these duties, Dr. Haviland spends many hours each month in the Association offices and in night and week-end meetings.



JAMES W. HAVILAND, M.D.
Secretary-Treasurer, W. S. M. A.

NON-SCIENTIFIC PROGRAM

WASHINGTON STATE MEDICAL ASSOCIATION

September 8-12, 1951

Sports, Entertainment and Business Sessions

Saturday, September 8

- 10:00 Defense Committee Meeting—338 Henry Bldg.
- 11:00 Finance Committee Meeting—338 Henry Bldg.
- 2:00 Board of Trustees Meeting—Olympic Hotel
- 6:00 President's Dinner for Board of Trustees and Convention Program Committee—Washington Athletic Club.

Sunday, September 9

- 10:00 Stockholders Meeting, Washington State Medical Bureau—Olympic Hotel
- 2:00 House of Delegates (First Session) — Olympic Hotel
- 6:30 No-Host Family Dinner (General Practitioner Award)—Olympic Hotel

Monday, September 10

- 4:30 Salmon Fishing Derby—Puget Sound
- 8:30 Annual Golf Tournament—Seattle Golf Club
- 6:30 Sportsmen's Banquet (for Fishermen and Golfers)—Seattle Golf Club

Tuesday, September 11

- 11:00 General Assembly—Olympic Hotel

Guest Speaker

MR. JOHN M. McCLELLAND, JR., a young man who has gone a long way in the field of journalism, is one of the principal speakers on the State Convention program.



MR. J. M. McCLELLAND

He came west to Longview with his family in 1923, when that city was founded. McClelland attended high school in the city and was graduated in journalism at Stanford University. Before he came back to Washington State to join the staff of the *Longview Daily News* he worked on California newspapers.

In 1940, John was appointed editor of the *News*, then four years' Naval service interrupted his newspaper career. He served on ships in many war theaters, emerging a lieutenant.

He has been an officer of Sigma Delta Chi, National Journalism Fraternity, since 1946, and now is national president.

He was first chairman of the editorial section, Allied Daily Newspapers of Washington, was twice winner of Washington State Press Club's award for "distinguished editorial writing," and is a member of the American Society of Newspaper Editors. He is a member of the Washington State Parks and Recreation Commission.

Mr. McClelland is the author of the volume "Longview, the Remarkable Beginnings of a Modern Western City."

At present, the Washington State Medical Association and the Allied Daily Newspapers are working toward the adoption of a Code of Cooperation with the Press and Radio, and Mr. McClelland will bring out important points to be covered in such an agreement during his talk before a general assembly at the Annual Convention.

Speakers' Program:

J. M. McClelland, Editor, *Longview Daily News*, "A Better Working Relationship Between the Journalism and Medical Professions"

K. L. Partlow, M.D., President's Address

12:00 Special Meetings:

Academy of General Practice—Olympic Hotel
American College of Surgeons (Organizational Meeting of Local Chapter)—Women's University Club)

5:30 - 12—Annual Banquet and Dance—Olympic Hotel

5:30 Refreshments—Olympic Bowl

6:00 Banquet—Georgian Room

9:00 Dance—Olympic Bowl

Wednesday, September 12

12:15 - 2:30—Public Relations Luncheon (Host: Washington State Medical Association) — Olympic Hotel

Guest Speakers:

Leone Baxter, "American Medicine Takes Its Case to the People"

Clem Whitaker, "Are the People Listening?"

2:40 House of Delegates (Second Session)—Olympic Hotel

Business Session

Election of Officers

Presidential Inaugural

6:00 Reception for New President—Olympic Hotel

SALUTE!

To you who are this state's progressive medical profession, the Metropolitan Building Company is happy to pay tribute on the occasion of your 62nd annual convention. We recognize your invaluable contribution to our state's development, through continuous medical research and advanced health care.

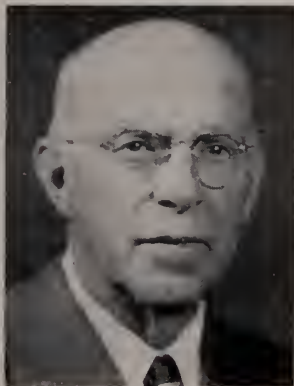
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RHODEHAMEL SELECTED AS OUTSTANDING G. P. FOR 1950-51

Spokane Man Gets Award for Distinguished Service

OVER 3,000 babies and 50 years after he began the practice of medicine in Spokane, Washington, Dr. Harry E. Rhodehamel has been named "General Practitioner of the Year" for the State of Washington. His practice in Spokane has spanned the years between calls in a horse and buggy, bicycle and street-



H. E. RHODEHAMEL, M.D.
Spokane

Dr. Rhodehamel was selected by the Washington State Medical Association as "The Outstanding General Practitioner of Washington for 1950-51." He will be presented an award for that honor at the Annual Convention, during the No-Host Family Dinner, Sunday, September 9, at the Olympic Hotel.

friends has been the compensation he sought for his untiring zeal and unflagging devotion to duty. As a doctor, he has brought help to those who needed it by restoring them to health and a happy life. Dr. Rhodehamel has no middle name, only the initial "E". It has many times been suggested that he substitute the name "Ethics" for lack of another name.

The doctor was one of the first in organizing Public Health in Spokane and as such he had a part in the building of the first Isolation Hospital in that area, his name appearing on the cornerstone of the building. Some of the projects to which the doctor devoted his time were: Furthering construction of the city wells in the Spokane Valley for the betterment of the health in the community, eliminating typhoid fever caused by water contamination. From 1937-1939 he served in the Health Division of the State Planning Council and assisted in outlining the health education program to be used in the state's public schools. Dr. Rhodehamel was a member of the Spokane Bureau of Health during the last few years before the start of the commission form of government there. He also was a member of the Executive Committee of the Public Health League of Washington from 1928 to 1939. One of his greatest contributions was as a member of the State Board of the Medical-Dental Advisory Committee in the establishment and development of the Medical Care of Old-Age Recipients. It was pioneering in welfare work.

He has always been a proponent of voluntary medical care, leading the establishment of it in the area by being one of the founders of the Medical Service Bureaus, both county and state, which is one of the first and most successful doctor-owned plans in the United States. Since 1933 he has been a member of the Board of Incorporators of the Spokane County Medical

cars to those of modern transportation. He started practice in Spokane on Sept. 9, 1900, and is still practicing full-time there at the age of almost 75, now serving the grandchildren of his early patients. During his professional life in Spokane he has seen it grow from plank sidewalks to paved boulevards; from 50 physicians and 36,000 population to 260 physicians and the population of 160,573, with the hospitals expanding from 170 beds in two small hospitals to the present-day 1200 beds in three Class A hospitals and a newly completed 200-bed Veterans Administration Hospital.

When recently asked, "Who have been your most important patients?" the doctor replied, "Humans." The fact that he has made a legion of

Bureau, serving as Trustee for two years. It was by his efforts that veterans in the State of Washington have free choice of doctors.

In addition to his professional affiliations, Dr. Rhodehamel has been influential in the Republican party in Spokane, although he always has refused official status. The doctor is affiliated with Harmony Lodge No. 8, F. & A. M., in Urbana, Ohio. At all times he has held Americanism and patriotism as one of the foremost aims of his life, as well as loyalty to organized medicine. He served as Captain in the United States Army Medical Reserve during World War I and as Chief-of-Staff of Emergency Defense at the Sacred Heart Hospital from 1942-1944 during World War II. He also was Senior Surgeon of the United States Public Health Service in 1943. President Roosevelt commended him for his work in the Office of Civilian Defense.

Dr. Rhodehamel was born in Piqua, Ohio, on March 7, 1876, son of George W. and Ruth E. (Fuller) Rhodehamel, both natives of that state. He is a great-grandson of Jacob Rhodehamel, who came to America from Germany in 1778, settled in Ohio and married Julia Mason, a descendent of the diplomat and statesman, John Mason. Dr. Rhodehamel's mother was descended from the well-known New England family of Fuller, whose history in this country begins with the "Mayflower."

Dr. Rhodehamel received his early education in the public schools of Urbana, Ohio, and afterward entered Starling Medical College at Columbus, now a part of Ohio State University. Here he prepared for his chosen profession and was graduated in 1900 with the degree of Doctor of Medicine. He also is an alumnus of the Ohio State University. On June 6, 1900, he married Bertha Sowers of Urbana, Ohio, daughter of the Rev. J. E. and Lucy (Isreal) Sowers.

He has made many contributions to the progress of medicine in Washington and has served in numerous positions of honor and responsibility. Dr. Rhodehamel has been a tireless speaker for many groups which needed a representative from the profession. He was the president of the Washington State Medical Association on its 50th birthday and the meeting was held in Spokane in 1939. As one of the founders of the Spokane Medical Library, he has served on the Board of Trustees since it was established in 1931.

Among his other offices he has been a member of the Medical Division of the State Planning Council 1939 to 1940; member of the Maternal and Child Hygiene Department of the State Board of Health 1941 to 1948; Assistant Medical Director of the State Department of Labor and Industries 1941 to 1945; Director of the Better Business Bureau from 1941 to date; Trustee of the State Tuberculosis League 1943 to 1947; Trustee of the Washington State Medical Association from 1928 to 1940. Dr. Rhodehamel also has been chairman of the obstetrical committee for Sacred Heart Hospital for 19 years. He is a member of the Washington State Medical Association, the Spokane County Medical Society, the American Medical Association, Washington State Obstetrical Association and the Pacific Coast Medical Executives' Conference.

It has been some time since he has gone hunting for more than mushrooms (he is an authority on them), but he is still an ardent fisherman. His sense of humor, his gift of telling a good story, his love of nature and people make him an endeared humanitarian. Every doctor in Spokane feels this honor given Dr. Rhodehamel by the Board of Trustees of the Washington State Medical Association is truly deserved.

Corbett Maintains Vigorous Schedule to Serve Profession

DONALD G. CORBETT of Spokane is completing three strenuous years in top offices of the Washington State Medical Association, after many other years of service with the State Association and his County Society and Medical Service Bureau.



DONALD G. CORBETT, M.D.
Spokane

He is ending a year as immediate past-president and chairman of the Association's Executive Committee, after having served as President and President-elect. During all that time he was a member of the Executive Committee and the Board of Trustees. He has been a member of the House of Delegates, was a Delegate to the A.M.A., and still is an alternate delegate.

Dr. Corbett was a trustee of the Washington State Medical Service Bureau and was President of the Spokane County Medical Service Bureau for which he served as trustee for many years.

He has shuttled back and forth between his home town and Seattle for years by airplane, train and automobile, in attending to Association business.

He is a member of the University of Washington Board of Regents, and is chairman of a sub-committee charged with bringing in recommendations for handling the Metropolitan Tract in downtown Seattle, to the best advantage of its owner, the University.

Fishing Derby Set for Monday Prizes Galore—Register Now

UNDER the expert leadership of Edmund H. Smith, Chairman of the Annual Convention Fishing Derby, physicians of the State Medical Association are plotting a sunrise onslaught against Puget Sound salmon on Monday, Sept. 10.

Chairman Smith will send out reservation blanks for this party in the very near future and urges an early return, so that boat parties for friends and fishing partners can be arranged.



EDMUND H. SMITH, M.D.

"The earlier you make your plans, the easier it will be to take care of you, and the more fun you will have," Dr. Smith said.

An over-all prize will be awarded the person catching the largest salmon and there will be attractive awards for doctors outside King County, for those living in King County and for Auxiliary members who wish to join the throng seeking an early morning catch.

Prizes will be awarded at the Annual Sportsmen's Banquet at the Seattle Golf Club Monday evening.

Dr. Smith says there will be boats and equipment for everyone. The more, the merrier, so make your plans now.

Technical Exhibitors Deserve Your Attention

(Editorial)

CONTRIBUTIONS by technical exhibitors for exhibit space at our annual conventions go far toward defraying the expenses of these annual sessions.

They help further the medical education of our members by giving the members latest information on developments of products the doctors use.

These companies are exponents of private enterprise and support the American way of medical practice.

The only way these concerns have in measuring their success at our meetings is by the number of physicians who visit their booths. If the companies do not receive your interest, they cannot justify the expense of attending our next meeting.

If our members show only mild interest in the exhibitors, they lose incentive for purchasing booth space.

Following is a list of the 1951 convention exhibitors. They deserve and should have your close attention.

Booth No.	Booth No.
1 C. B. Fleet Co., Inc.	36 The Harrower Laboratory, Inc.
2 M & R Dietetic Laboratories	37 Medical Placement Bureau
3 Don Baxter, Inc.	38 Medco Products Company
4 Ames Company, Inc.	39 Shaw Supply Co., Inc.
5 Abbott Laboratories	40 Pet Milk Company
6 C. V. Mosby Company	41 Sharpe & Dohme, Inc.
7 Gerber Products Company	42 J. W. Stacey, Inc.
8 Haack Laboratories, Inc.	43 Holland-Rantos Co., Inc.
9 Sandoz Pharmaceuticals	44 Bilhuber-Knoll Corp.
10 Doho Chemical Corporation	45 Camel Cigarettes
11 Davis & Geck, Inc.	46 Paravox, Inc.
12 Walker Vitamin Prod., Inc.	47 Chicago Pharmacal Co.
13 Westwood Pharmaceuticals	48 Sanborn Company
14 White Laboratories, Inc.	49 Coca-Cola Company
15 Winthrop-Stearns, Inc.	50 The Stuart Company
16 Endo Products, Inc.	51 Consolidated Dairy Products Co.
17 U. S. Vitamin Corporation	52 The Borden Company
18 Lederle Laboratories Div.	53 Ortho Pharmaceutical Corp.
19 Western X-Ray Company	54 Melody Company
20 E. R. Squibb & Sons	55 Eli Lilly & Company
21 Burroughs Wellcome & Co.	56 Picker X-Ray Corporation
22 Northwest X-Ray Service	57 Carnation Company
23 Shadel Sanitarium	58 J. B. Lippincott Co.
24 G. D. Searle & Co.	59 Ayerst, McKenna & Harrison, Ltd.
25 Schering Corporation	60 Ciba Pharmaceutical Products, Inc.
26 Baby Development Clinic	61 Westinghouse Electric Corp.
27 Medical-Dental Personnel Registration	62 S. E. Massengill Company
28 William S. Merrell Co.	63 H. J. Heinz Company
29 Parke, Davis & Co.	
30 Philip Morris & Co., Ltd., Inc.	
31 Eaton Laboratories, Inc.	
32 Mead Johnson & Company	
33 General Electric X-Ray Corp.	
34 The National Drug Co.	
35	

WATERFRONT HOME For Sale or Trade

Lovely 7-room waterfront home on Vashon Island: four bedrooms, double plumbing, hot water heat, basement. Located on 8-acre tract with excellent clam beach (no bank), fruit orchard, 4-stall stable, 3 garages, unobstructed panoramic view of Seattle and Mt. Rainier. Excellent schools. Will consider trade for Seattle property. Telephone owner.

VASHON 4571

M. Shelby Jared, Speaker, House of Delegates



M. SHELBY JARED, M.D.

M. SHELBY JARED, for twenty years a member of the House of Delegates of the Washington State Medical Association, is completing his fifth year as Speaker. He has been a member of the Board of Trustees for seven terms.

Dr. Jared was President of King County Medical Society, Secretary of the Society and was a member of its Board of Trustees for ten years. He was a Trustee of the King County Medical Service Bureau for ten years and is now the Bureau's Medical Director, having served in that capacity for five years.

ical Director, having served in that capacity for five years.

"Not Too Late to Enter Art and Hobby Show" . . . Powell

PLANs for a Physicians' Art and Hobby Show during the State Convention are going forward, with every indication of success, according to Archie Powell, chairman.

During the past several Conventions displays of this sort have been held and plans this year are to make a larger and more comprehensive showing.

The exhibit will be composed of oil paintings, water colors, sketches, photographs—both colored and black and white, and displays of hobbies of all sorts. Naturally, we want as large a display as possible, Dr. Powell said.

Those physicians wishing to enter exhibits in the show are requested to write the chairman, in care of the Central Office, immediately. Exhibitors can bring their entries, or send them to the Central Office, but a letter indicating the desire to enter exhibits, with a description and space needed, should be sent to the Central Office immediately, so arrangements for space can be made.

President's Cup to Be Awarded Golf Tournament Winner

WASHINGTON State Medical Association will hold its Annual Tournament at the Seattle Golf Club on Monday, Sept. 10, with a variety of competitions arranged according to teams, specialties, classes and maturity. Starting times will range from 8:00 a.m. to 2:00 p.m.

Four-man teams will qualify for a special trophy during the morning and the two best teams will meet at match play in the afternoon. Tee-off for this event is 8:30 a.m.

The championship round will be for 36 holes, gross. The President's Trophy event will be 36 holes, net. There will be special events and trophies for the Sectional contests.

The Maturity will be for those 55 years of age and over.

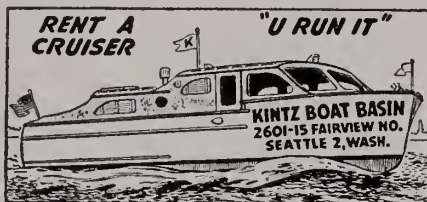
P. N. G. A. Club members should have a certificate of their club handicap available. All other players will be handicapped according to the Automatic System. Play will be according to U. S. Golf Association Rules.

Evening entertainment will start at the Club House at 6:30, and the Sportsmen's Dinner will begin at 7 p. m. Both golf and fishing prizes will be awarded during the dinner hour.

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CARE AND TREATMENT OF FISHPOX (SALMON VARIETY)

By MARY E. FREAR, Staff Reporter



Identify these ten fishermen. First physician to send the correct answer to NORTHWEST MEDICINE, 323 Douglas Bldg., Seattle 1, gets a prize—dinner for two at Moison Blanc, 308 Marion St., Seattle, to be used any time during the Convention. Chairman of the committee and any employee of NORTHWEST MEDICINE exempt from this offer.

THE rapid increase of the incidence of fishpox in the Pacific Northwest has given rise to a pressing need for more detailed information on certain aspects of the disease. While this disease is endemic in all parts of the United States and Canada, certain peculiarities of the affliction make it more prevalent here than anywhere else in the country. Fishpox is water borne, and large bodies of water, such as Puget Sound, surrounded by evergreen forests and mountains of great height and flawless beauty, prove to be a ripe breeding ground.

A typical clinical picture presents a sufferer with both mental and physical disabilities. The patient experiences an overpowering need for fresh air, especially blowing off salt water. Inability to walk by sporting goods stores and tackle shops is noted. Displays of large silver and king salmon will frequently cause excessive salivation and slight but noticeable exophthalmos. Patient will also complain of inability to concentrate on mundane chores, inclination to stare out of windows, lack of desire to report to the office on sunny days.

There is no known cure for fishpox, but the patient can be made very comfortable and can learn to live with the disease without too much interference in normal behavior pattern. If the patient is allowed a certain amount of time in sporting goods stores, immediate pressure will be removed. As a matter of fact, a good tackle salesman can be of definite therapeutic value. He will undoubtedly recommend the purchase of assorted Coho flies. These are *not* to be taken internally. Instruct the patient to carry these rather large fishing flies with him whenever he is near salt water.

If the patient is allowed to acquire a certain amount of tackle, such as a rod, reel and line which the tackle experts will also recommend, either by purchase or rental, it will act as a temporary sedative and relieve the patient of the most painful symptoms of the disease. However, best results are obtained by travel. This need not be done in excess. Elliott and Shilshole Bays, which are right in Seattle's front yard, are very effective. Only one hour away from Seattle lies Whidbey Island, which has proved to be one of the finest treatment areas for Fishpox (Salmon variety) in the United States. A number of fishing resorts are located on this beautiful island, and these resorts are staffed with well-trained personnel who will handle your patients with skill and gentle understanding.

Modern therapy for Fishpox (Salmon variety) recommends trolling the Coho fly on 25 to 75 feet of line, quite fast. Try zig-zagging as you troll. If fish are not showing on the surface, add an ounce of lead and troll slightly slower. If the patient sees seagulls feeding on candlefish or herring, he should hasten to troll through, since the salmon follow the feed as well as the seagulls. Even the patient suffering his first attack will find it easy to catch fish in this fashion.

Summary: This disease is very contagious. It has been known to run through whole families, and is frequently hereditary. Public Health officers have been unable to control Fishpox—many of them have the disease themselves. Don't be alarmed if you contact Fishpox (Salmon variety) while in Seattle. Don't aggravate the disease by ignoring it—go fishing! Good luck, and tight lines!!!



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WOMAN'S AUXILIARY ANNOUNCES TENTATIVE PROGRAM; ALL IN ATTENDANCE INVITED TO TAKE PART—SEPTEMBER 9-12

THE TWENTIETH annual meeting of the Woman's Auxiliary will be held at the Olympic Hotel, Seattle, on September 9-12, inclusive.



MRS. R. M. SCHULTE
Spokane, President, Woman's
Auxiliary to the Washington
State Medical Association

Purpose of the annual meeting is to hear reports of officers and standing committee chairmen; to elect and install new officers, and to hear a report of the National Convention from delegates who attended.

There will be a school for the chairmen of the following standing committees and for presidents and presidents-elect:

Today's Health, Public Relations, Organization and Legislation.

All doctors' wives are welcome to sit in on all sessions, whether or not they are members of the Auxiliary. Registration, however, is necessary.

The tentative program is as follows:

Sunday, September 9

- 12:00-6:00 Registration, Junior Ballroom Mezzanine, Olympic Hotel.
- 3:00 Nominating Committee Meeting, President's Suite, Olympic Hotel.
- 4:00 Finance and Budget Committee Meeting, President's Suite, Olympic Hotel.
- 6:00 No-Host Family Dinner, Olympic Bowl, Olympic Hotel. (Everybody welcome.)

Monday, September 10

- 9:00-4:00 Registration and Information, Junior Ballroom Mezzanine, Olympic Hotel.
- 9:00-12:00 Golf and Luncheon, Broadview Golf Club, Mrs. J. N. Nelson, Chairman.
- 9:30 Pre-Convention Board Meeting, Parlors E and F, Olympic Hotel.
- 12:30 Past State Presidents' Luncheon, Women's University Club, Mrs. Roger Anderson, Chairman. (Past Presidents only.)
- 6:00 Reception and Dinner, in honor of Mrs. H. F. Wahlquist, National Auxiliary President, Washington Athletic Club.
Hostesses: Pierce, Whatcom and Skagit County Auxiliaries—Mrs. R. L. Zech, Mrs. Morris Hecht, Chairmen.

Tuesday, September 11

- 9:00-12:00 Registration, Junior Ballroom Mezzanine, Olympic Hotel.
- 9:00-11:30 Opening of General Sessions, Parlors E and F, Olympic Hotel.
Invocation—Dr. John Paul Pack.
Welcome—Mayor William F. Devin, Seattle.
Response—Mrs. D. J. Lawson.
Greetings from Washington State Medical Association—Dr. James W. Haviland, Secretary-Treasurer.
Introduction of Mrs. Wahlquist and response.
Presentation of President-Elect, Mrs. A. J. Bowles, Seattle.
Roll Call and Reading of Minutes—Mrs. H. L. Leavitt, Recording Secretary.

Credentials and Registration Report—Mrs. Sherod Billington, Chairman.
Address of President, Mrs. R. M. Schulte.
Report of Officers.

- 12:30 Annual Auxiliary Luncheon, Sunset Club.
Speakers' Program—Chairmen: Mrs. George Hanson, Mrs. Charles McArthur.
Hostess Counties—Cowlitz, Kitsap, Thurston-Mason County Auxiliaries.
Speakers—Honorable Harry Cain, U. S. Senator, and Mrs. H. F. Wahlquist, National Auxiliary President.
- 3:00-5:00 Afternoon Business Session, Parlors E & F, Olympic Hotel.
Announcements—Mrs. Purman Dorman.
Reports of Standing Committee Chairmen.
Report of Nominating Committee, Mrs. E. L. Calhoun, Chairman.
Report of Finance Committee, Mrs. James E. Cunningham, Chairman.
Reports of nine County Presidents: Chelan, Clark, Cowlitz, Benton-Franklin, Grays Harbor, King, Kittitas and Lewis.
Report of Delegate to National Convention.
- 6:00 Annual Banquet and Dance, Olympic Hotel. (Everybody welcome.)



MRS. A. J. BOWLES
Seattle, President-Elect
Woman's Auxiliary to the
Washington State Medical
Association

Wednesday, September 12

- 8:30-9:30 Registration, Junior Ballroom Mezzanine, Olympic Hotel.
- 8:00-9:30 Schools of Instruction, Olympic Hotel:
Today's Health and Bulletin—Parlor A.
Presidents and President-Elect and Public Relations—Parlor B.
Legislative Chairmen and Program—Parlor C.
- 9:30 General Sessions—Parlors E and F.
Roll Call.
Minutes of Tuesday's Sessions.
Announcements—Mrs. Purman Dorman.
Reports of County Presidents: Cowlitz, Okanogan, Pierce, Skagit, Snohomish, Spokane, Thurston-Mason, Walla Walla Valley, Whatcom and Yakima.
Reports of Resolutions Committee—Mrs. L. J. Hakela.
Memorial—Mrs. J. H. Berge.
Report of Nominating Committee—Mrs. E. L. Calhoun.
Election of Officers.
Installation of Officers by Mrs. H. F. Wahlquist, National Auxiliary President.
- 12:00 Public Relations Luncheons for Doctors, Wives and Guests, Olympic Bowl. (Host: Washington State Medical Association.)
- 3:00 Post Convention Board Meeting, Mrs. A. J. Bowles presiding—Parlors E and F, Olympic Hotel.
- 6:00 Reception for New President, Dr. R. A. Benson, Junior Ballroom.

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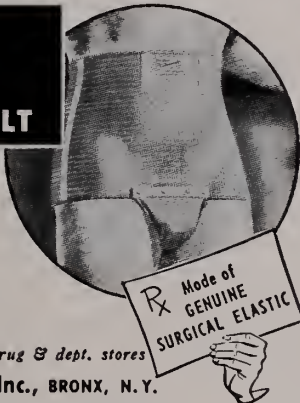
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FALL MEETING

Saturday, Sept. 8, 1951—Washington Athletic Club—Seattle, Washington



E. W. CARTWRIGHT
Associate Clinical Professor
Obstetrics and Gynecology
University of Southern California



GILBERT J. VOSBURGH
Professor of Obstetrics and Gynecology
Western Reserve School of
Medicine



ALBERT W. HOLMAN
Former Associate in Obstetrics
and Gynecology
University of Oregon Medical School

Tentative Program

- | | |
|--|--|
| 9:30 Registration | 4:00 Dr. E. W. Cartwright
"Recent Advances in Gynecology"
Film "Vaginal Hysterectomy" |
| 10:00 Dr. Gilbert J. Vosburgh
"Recent Advances in Obstetrics" | 5:30 Business Meeting |
| 11:00 Dr. E. W. Cartwright
"Bleeding in the Third Trimester of Pregnancy" | 6:00 Social Hour |
| 12:00 Luncheon and Symposium
DR. ALBERT W. HOLMAN <i>Moderator</i>
1. Intrapartum Surgery
2. Premature Labor
3. Rh Negative Patients | 7:00 Banquet and Symposium
DR. ALBERT W. HOLMAN <i>Moderator</i>
1. Diabetes in Pregnancy
2. Acute and Chronic Hydramnios
3. Hypertensive Disorders in Pregnancy |
| 3:00 Dr. Gilbert J. Vosburgh
"Some Aspects of Placental Permeability" | |

Registration limited to 200. Association members given priority until Sept. 1. Non-member applications accepted in order of receipt.

Registration fee \$8.00, includes luncheon, social hour and banquet.

REGISTRATION

Washington State Obstetrical Association

FALL MEETING, SEPTEMBER 8, 1951

WASHINGTON ATHLETIC CLUB, SEATTLE, WASHINGTON

Enclosed is registration fee of \$8.00 for the fall meeting, which is refundable upon notification prior to meeting date. Enclosed are questions or subjects I would like included in symposia discussion.

(Signed).....

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SIXTIETH ANNUAL MEETING JUNE 16-18, 1952 SUN VALLEY

President, A. M. Papma, M.D., Boise

Secretary, R. S. McKean, M.D., Boise

Exec. Secy., Mr. A. L. Bird, 305 Sun Bldg., Boise

OFFICERS—1951-1952

President.....Alfred M. Papma, M.D., Boise
 Past-President.....Russell T. Scott, M.D., Lewiston
 President-Elect.....Wallace Bond, M.D., Twin Falls
 Secretary-Treasurer.....Robert S. McKean, M.D., Boise

Delegate to the American Medical Association.....Hayt B. Waalley, M.D., Idaho Falls
 Alternate Delegate to the American Medical Association.....Raymond L. White, M.D., Boise

COUNCILORS

First District (Boundary, Banner, Kaatenai, Benewah, Shoshone, Latah, Clearwater, Nez Perce, Lewis, and Idaho Counties):

Alexander Barclay, Jr., M.D., Cœur d'Alene

Second District (Adams, Valley, Washington, Payette, Gem, Boise, Canyon, Ada, Elmore, and Owyhee Counties):

Harold E. Dedman, M.D., Boise

Third District (Camas, Blaine, Gading, Lincoln, Jerome, Minidaka, Twin Falls, and Cassia Counties):

Charles B. Beymer, M.D., Twin Falls

Fourth District (Custer, Clark, Fremont, Jefferson, Butte, Madison, Tetan, Banneville, Bingham, Power, Bannack, Oneida, Caribau, Franklin, Bear Lake, and Lemhi Counties):

E. Victor Simisan, M.D., Pocatello

Minutes of the 59th Annual Meeting House of Delegates—Idaho State Medical Association Sun Valley, June 17-20, 1951

The House of Delegates of the Idaho State Medical Association was called to order by President Russell T. Scott at 1:30 p. m., June 17, 1951, in the Skier's Cafe at Sun Valley.

The Councilors, Alexander Barclay, Harold Dedman and Wallace Bond, were appointed as the Credentials Committee and certified that all delegates present could be seated.

Roll call showed a quorum present.

President Scott reviewed activities of the association since the last meeting and expressed his appreciation for the excellent cooperation and assistance so generously given him by the Councilors, component society officers, committees and the membership at large.

A review of action taken by the Councilors in administering affairs of the association during the past year was also presented by Dr. Scott.

President Scott announced that members of the Resolutions Committee had been appointed several months ago made up of the following:

Frank L. Fletcher, Boise, Chairman; Charles B. Beymer, Twin Falls, and M. M. Graves of Pocatello, and that all of the component societies as well as members of the association had been requested to send resolutions to the committee for consideration by the House of Delegates during the present session.

President Scott appointed Roy Eastwood, Lewiston; Franklin David, Boise, and Dauchy Migel, Idaho Falls, as members of the Auditing Committee.

The following were named members of the Nominating Committee:

Donald K. Worden, Lewiston, Chairman; Charles A. Terhune, Burley; Jerome K. Burton, Boise, and Corwin E. Groom, Pocatello.

The minutes of the 58th annual meeting, as published in NORTHWEST MEDICINE, were approved.

Reports of Committees

Report of Program Committee 1950-51

The following outstanding men accepted the invitation of the Program Committee to be guest speakers at the 59th annual meeting of the Idaho State Medical Association to be held at Sun Valley, June 18 to 20:

George W. Thorn, M.D.; Curtice Rosser, M.D.; Donald G. Tollefson, M.D.; D. L. C. Bingham, M.D.; Harry H. Gordon, M.D., and John Z. Bowers, M.D.

The Program Committee began working on the program for this year immediately after the 58th annual meeting last year. Through the able cooperation of our Executive Secretary the session was mentioned in the News Letters beginning in January and it has been mentioned in every issue since. Twenty-five hundred advance announcements were mailed to physicians in Wyoming, Oregon, Nevada, Utah, Washington and Montana. Officers of each association in states other than those mentioned also received the announcements.

We received publicity in *Journal of the American Medical Association*, three pages in *NORTHWEST MEDICINE*, a mention in the *Rocky Mountain Medical Journal* and in other journals in the east.

One thousand programs were printed and 450 of them were mailed to each practicing physician in the state on May 22; copies were also mailed to officials of the American Medical Association and to a number of out-of-state physicians who had requested the program.

Approximately \$1,000 was realized through advertising in this year's program.

I wish to express my appreciation for the excellent cooperation given me by the other members of the program committee as well as Dr. Scott and Mr. Bird.

The dates for next year's session at Sun Valley are June 16, 17 and 18, 1952, with the House of Delegates meeting on Sunday, June 15, for a business session.

ALEXANDER BARCLAY, JR., Chairman

The report was unanimously approved.

Industrial Accident Committee

On Nov. 1, 1950, President Russell T. Scott appointed the following men as members of your committee: A. B. Pappenhagen, Orofino; M. M. Graves, Pocatello; Delbert A. Ward, Boise; W. R. Abbott, Idaho Falls.

This committee functioned as a unit with only one formal meeting with the Industrial Accident Board which was held in Boise on April 17 and 18, 1951, in accordance with the agreement made with the Board and the Sureties two years ago. At this time certain changes were made in both the Manual and the Fee Schedule with which you are familiar, inasmuch as they have been mentioned previously in the *News Letters*.

The main item of debate centered around the charges for first and subsequent visits. An agreement was made with the Sureties that the first charge be left at \$4.00 and subsequent charges to be \$3.00, but this was not accepted by the Board, and the \$4.50 original, and \$2.50 subsequent, decision was handed down.

Four disputed cases have been settled by the Committee during this year, and one other is pending at this time. It has not been necessary at any time to have an opinion of the Board for this, nor has any case come before them officially in this respect.

The Committee is still at work on a proposed revision of the partial indemnity schedule, and hopes to have some modification of the McBride method ready for serious discussion next year. Necessarily, this will have to be passed by the Industrial Accident Board, and probably by the next Legislature, but we have indications that this will not present a serious problem.

Dr. Abbott of Idaho Falls expired suddenly in March and Roscoe Ward, Boise, was appointed to fill the unexpired term of membership. J. B. Morris, Boise, was appointed as Radiological Consultant to the Committee in March, and also for the April 17 meeting.

It is suggested that inasmuch as the radiologists of the State are to form their own association, that one of their members, preferably located in Boise, be assigned as Consultant to this committee, for we have found that almost yearly there are certain items of radiology which come up for discussion.

The terms of Drs. Pappenhagen and Ward will expire in 1951, and this committee urgently requests they be reappointed so as not to disrupt work which is going on at present, and particularly to keep our present contacts both with the Board and the Sureties.

Appreciation is expressed to the members of the association for their help and cooperation when called upon for aid during this past year.

QUENTIN W. MACK, *Chairman*

The report was unanimously approved.

Poliomyelitis Committee

On Nov. 1, 1950, President Russell T. Scott appointed the following physicians as members of the Poliomyelitis Committee: M. B. Shaw, Boise; J. K. Burton, Boise; Robert S. McKean, Boise; W. S. Douglas, Lewiston; W. R. Hearne, Pocatello, and N. H. Battles, Idaho Falls.

There has been no formal meeting of this committee inasmuch as the polio situation during the past year has not been epidemic in character, and only a more or less continuous run of cases have been seen. The basic precepts set up in the 1948 and 1949 epidemics are still in effect, and there has been no good reason to make any drastic changes to date. The designation of hospitals, medical teams, and dispersal of equipment has continued as it has been in the epidemic years.

In May, 1951, Governor Len Jordan appointed a new Idaho State Poliomyelitis Planning Committee with instructions to review the workings of the previous committee and to make recommendations for revision of details pertinent to the handling of another epidemic. Drs. Shaw, Fletcher, and Mack are the medical representatives of this committee.

In view of the above, the Poliomyelitis Committee of the Medical Association has had little to do, and

will await the recommendations of the State Planning Committee.

QUENTIN W. MACK, *Chairman*

The report was unanimously approved.

Workmen's Compensation Interim Committee

At the request of the Legislative Interim Committee studying the Workmen's Compensation Law headed by Mr. Paul Vernon, State Representative from Ada County, Roy Freeman, J. B. Morris and Quentin W. Mack were requested to serve in an advisory capacity to this committee.

Two meetings were held with the Interim Committee which were more or less informal and recommendations were made by the Committee to the Legislative body. As you know, the Interim Committee was studying Workmen's Compensation Law in an effort to clarify a great many of the compensation laws and to help in simplifying the law to make it more practicable and more modern.

Inasmuch as our suggestions were primarily in an advisory capacity, no specific recommendation can be given since we simply advised this committee on the various phases of this law. As this committee acted only in an advisory capacity the members of the committee feel there is no necessity of becoming a permanent committee.

If the association is requested to form such a committee again, it should be only on a temporary basis.

QUENTIN W. MACK, *Chairman*

The report was unanimously approved.

Necrologist Report

During the past year six deaths of physicians who practiced in Idaho were reported. A seventh on our list is Owen D. Platt, whose death, near the age of 74, occurred in September, 1949, although no official word of it was received at the State Office until this year. He had practiced continually in St. Maries for 39 years, when it appeared that he merely faded away.

The first death in the past year was that of Virgil C. Belknap of Nampa, who passed away Sept. 20, 1950. He practiced for 30 years in Prairie City, Oregon, before coming to Nampa in 1924. He was very active in Masonic orders and an Honorary Member of the Idaho State Medical Society. He left a brother in Nampa and a son in Ontario, each practicing medicine.

Sept. 22, 1950, two days after Dr. Belknap's passing, relatively young Dr. John McGarry of Coeur d'Alene died after having practiced in Idaho only 20 months. He was a member of the A. M. A., his county society, and the State Medical Association.

Nov. 1, 1950, Dr. Newton Farrell died in American Falls at the age of 63. He had practiced there for 18 years after toiling in Mackay for 10 years. He was a member of the State Medical Association, the A. M. A., and his district medical society. He was also known for his interest in boating and flying.

Dec. 1, 1950, Dr. Harold G. Nokes died in Boise of a heart condition at the age of 56. He had resumed his surgical career after several months of illness and had just finished an operation a few minutes before he dropped off. Before starting to study medicine, he went on an L. D. S. mission and also served in France in the First World War. He graduated from the University of Oregon in 1927, and after his internship came to Boise where he practiced for about 23 years. He was a member of the State Medical Association, the A. M. A. and his district society.

This March 9, Dr. Dan C. McDougall, age 52, passed away in Pocatello of a coronary disease. He took his premedical training at the University of Idaho. He pioneered pediatrics in eastern Idaho, was a Diplomate of his American Board and a member of the American Academy of Pediatrics. He was known as an ardent skeet artist, which had seemed to have benefitted his health.

The most recent loss was that of Dr. Wm. R. Abbott, who died in Idaho Falls, this March 20, of a heart attack. A native Idahoan, he was born in Mountain Home, educated at the University of Utah and Rush Medical School. A veteran of World War II, he served four years with the U. S. Army in Brazil, Alaska, and the United States. He was a Fellow of the American College of Surgeons and a member of the State Medical Association's Industrial Accident Committee.

Four of the six deaths during the current year were men under 60, of which three were thought to be cardiac. No former president of the association passed on this year.

Mr. Chairman: I ask for the acceptance of this report and that we all stand for a few moments of silent commemoration of our departed associates.

HARMON TREMAINE

The report was unanimously approved.

Rural Medical Care

For the second year I have had the privilege of representing the Idaho State Medical Association at the National Conference on Rural Health, held in Memphis, Tennessee, February 22, 23 and 24, 1951. This was the 6th National Conference sponsored by the A. M. A. and this year's theme was: "Why Wait—Let's Do It Ourselves." It was felt that this was the most successful meeting to date. The reports throughout the country showed great progress in the Rural Health Work. As yet, Idaho has sent no representatives from its Farm Bureaus or its Extension Departments.

Organization of Public Health Councils was again greatly stressed. Large numbers were reported organized—1,190 in the United States or one-third of our counties have Health Councils which are planning and advisory in nature and advocating local participation for local needs. As Dr. Lull stated, if we have government transfusions in our communities we find they take 500 cc's out of the right arm and give us back 300 cc's in the left arm.

Numbers of states reported holding State Rural Health Conferences. Very interesting and educational were the County Health Surveys conducted in Clinton County and Columbiana County, Ohio. Copies of these reports are available.

Dr. E. K. Yantes discussed the medical aspects of the Clinton County Survey at the meeting on Feb. 22, which was the day of meetings for the medical representatives of each state. He also discussed his survey at a meeting held on Feb. 23, as a means of showing what the Council has done and is doing.

The first day the welcome was given by F. J. L. Blasingame of the Board of Trustees of the A. M. A. He stated that Rural Health Committees are bearing fruit in wider availability of medical care in agricultural areas. He pointed out that there are fewer complaints that vast areas are without adequate medical services.

Responsibilities of Rural Health were discussed by Mr. Aubrey D. Gates, National Field Director, as well as F. S. Crockett, Chairman of the Committee of Rural Health. Problems of Providing Hospitals in Rural Areas were presented by Drs. W. A. Wright, Williston, N.D.; Allen T. Stewart, Lubbock, Texas, and W. J. Weese, Ontario, Oregon. Three discussion periods in which all the doctors participated were also held.

General meetings opened Feb. 23, with an address by George Lull who encouraged small communities, adjacent to industrial areas, to consider Civil Defense Programs. Dr. Lull pointed out that while such areas are not likely to be in the target area in an all-out attack on this country, they will be called on to handle the casualties from damaged and destroyed industrial cities. Small communities will be required to house, feed, and look after the injured from a nearby target area, he said.

This was followed by the addresses of Dr. Crockett and Mr. Aubrey Gates. Dr. Crockett stated that the

Rural Health Conferences were not developed as a doctor's plan, but were developed in an atmosphere of mutual trust and good will and of neighbors meeting to solve community problems in which we all have an equal interest. No group has claimed a preferred or dominant position.

In his talk on the Meaning of Rural Health, Mr. Gates pointed out that the life expectancy of the people of the United States is a thing that has exceeded any other achievement in the world. He pointed out that even though there is a shortage of doctors in some rural areas, there is still a difference in medical care and health. Medical care, he stated, is a purchasable service. We have an ailment, we go to a doctor. He gets the symptoms, makes a diagnosis, and prescribes for restoration of our health. For that we pay. But, for our health in rural areas, urban areas, or wherever we are, our total health we, personally, are responsible. We are responsible for the health of our communities. He related an example of a patient with malaria who goes to the doctor, who makes a diagnosis and prescribes a treatment. But if the patient returns home and fails to screen and clean his premises and rid his place of breeding places of the mosquito, then he would continually become infected and it would make no difference how much and how good was medical care available to him. Communities must accept the responsibilities for nutrition, environment, sanitation, and immunization against infectious diseases if good health is to be attained.

Mrs. Shelby Carr of Richmond, Ky., demonstrated with pictures the work started in rural schools under the auspices of the Medical Auxiliary. She showed how a group of energetic and hard-working women proved that poverty conditions can be eased by a strong determination of people to help themselves.

A very interesting and entertaining skit was conducted by members of the conference demonstrating the organization of a County Health Council.

The evening program was addressed by Haven Emerson, who spoke on the work of the Public Health Service. He showed that intelligent spending for prevention of disease will greatly reduce the total expense of medical care.

Mrs. Charles Sewell spoke on "Let's Try the American Way." She outlined the work of the Rural Health Conference, the good accomplished, and the necessity to carry on. Mrs. Sewell is one of the originators of the Rural Health Organization. She told of the pre-paid medical insurance of the American Farm Bureau Federation, also of scholarships offered by the Associated Farm Women.

On Saturday a panel "Following Through Back Home" was conducted by this group. Eight leaders of representative groups made statements of what the conference has meant to them and what can be accomplished by various organizations at the community level.

George F. Bond of Bat Cave, North Carolina, spoke on a plan for Rural Medical Services. He called attention to the fact that more small hospitals or workshops were needed. He stressed the fact that too many hospitals have been built that are too large for the community and that careful planning is needed to establish the type of care required by the community. He also stressed the fact that better care can be given in central hospitals than in the homes, and more doctors would be willing to practice in a setup that would not require so much driving, or in homes, when of a necessity, they could not give the best medical care.

Dean S. Luce, Canton, Mass., General Practitioner of the year, was one of the luncheon speakers. In commenting on the growth of voluntary health insurance programs, he said, "Persons who can spend money for television, radio, movies, cigarettes, and liquor should be able to pay a small sum for health insurance. Surely, they are not indigent and should not require government compulsion in order

to protect themselves from the expenses arising from sickness."

He was followed by Elmer L. Henderson, President of the A. M. A. He characterized the Conference as "heart-warming, stirring proof that Americans still want to, and can, face problems squarely and meet them vigorously on their own initiative." He cited the progress in medicine which has given physicians the ability to provide more healing care than ever before.

The concluding speaker was Mr. Ed Lipscomb, Director of Public Relations of the National Cotton Council of Memphis, Tenn. Mr. Lipscomb gave a very powerful talk on the problems facing us today as a nation. He warned against "making concessions which tend automatically toward a perpetual program of private life by public plan." He said we are in the midst of an all-inclusive world-wide battle for men's minds—a global war of ideas and ideals—a finish fight to decide whether the State shall be the incidental servant of man, or his Supreme Sovereign.

We have two jobs to do to protect ourselves as a nation; first is to protect ourselves from foreign enemies and this job requires production—production of all things necessary to military strength. We must, also, produce by abstinence or the simple procedure of not consuming. The second is the job of protecting our domestic front and our national character. We have seen the initiation of definite plans and strong campaigns to socialize some of our basic institutions and services—agriculture, medicine, housing. We came face to face with the imminent danger of losing the one great freedom from which all other freedoms spring—freedom from government encroachment.

From all about us comes the clear warning that there can be no emergency so great that the salesmen of statism will not seek to capitalize upon it for the advancement of their ends and the perpetuation of whatever progress they may be able to make in the name of temporary necessity.

Why did we escape socialization of medicine last year? It was not because a few thousand doctors objected, but because those doctors had the sense and good judgment to know it could be defeated only with the support of public opinion.

Public opinion is going to be molded, either in the direction you want it to go, or in another. "I therefore urge you," he said, "above all not to underrate the importance or power of your own personal effort."

Idaho should join the national program of organizing Health Councils.

MURLAND F. RIGBY, *Chairman*

The report was unanimously approved.

Annual Report of Secretary-Treasurer

Included in this report is a summary of the financial condition of the Idaho State Medical Association. The annual audit of the association's books from August 1, 1950 to April 30, 1951, was completed on May 25 by the accounting firm of Elmer W. Fox, Certified Public Accountant, Boise, Idaho.

It is my privilege to report that all receipts and expenditures of the association have been accounted for, and we have a comfortable balance on hand.

On Page 5 of this report, which has been mimeographed for your information, you will find a resume of the association's assets.

As of April 30 our balance in the General Fund amounted to \$12,312.63. At our meeting last September, our General Fund balance amounted to \$8,452.72. Thus this year we have increased our General Fund balance by \$3,859.91.

The association's Savings Account contains \$1159.73. No deposits or withdrawals occurred during the past year. The association's Educational Fund contains a balance of \$1351.79. The association's Welfare Fund contains \$6,131.25, making a total of \$20,955.40 cash on hand.

The Idaho Medical Foundation Fund contains \$13,727.00 in Governmental Bonds with a maturity value of \$18,550.00.

Total assets of the Idaho State Medical Association, as of May 25, 1951, therefore, amount to \$36,491.80.

Sources of revenue to the association for the past nine months are as follows:

Membership dues	\$ 6,862.00
Welfare dues	3,730.00
Registration fees	2,226.13
Interest	22.84
A.M.A. refund for collecting dues.....	601.47
Total	\$13,442.44

Expenses for the past year totaled \$10,623.98, and were made as follows:

Convention	\$ 2,374.99
Legal and Auditing	640.00
Office Expense	443.60
Printing and Stationery.....	187.39
Salaries	2,069.94
Telephone and Telegraph	678.45
Traveling (committees, officers, etc.)	2,485.81
Rent	996.00
Meetings and Miscellaneous	714.90
Bond (president, secy.-treas., office staff)	32.90
Total	\$10,623.98

At last year's session, you approved the expenses for Officers of the Auxiliary not to exceed \$500. This amount has been expended for travel of Auxiliary officers to national meetings and meetings of the Auxiliary within the state, and is accounted for under the heading of Office Expense and Travel.

The membership in the state association during the past year has again been slow. As of April 30, our paid-up membership record stood at 340, which is far below our estimated potential.

Of the 340 paid-up members, 337 paid the 1951 membership dues in the American Medical Association.

If you have read the *Journal* and proceedings of the House of Delegates of the American Medical Association you will know that membership is obligatory this year and also for 1950.

I feel it is extremely timely to note a few facts about the A.M.A. membership dues.

The A.M.A. membership dues are levied on "active" members of the association. An "active" member is one who is entitled to exercise the rights of active membership in his constituent association, including the right to vote and hold office as determined by his constituent association, and who has paid his A.M.A. dues.

A. M. A. memberships are payable through county or constituent state medical associations.

The \$25 membership includes the *Journal*.

The following may be excused from paying the \$25 membership fee in the A. M. A.:

1. Members for whom the payment of dues would constitute a financial hardship as determined by their local medical society.
2. Members in actual training for not more than five years after graduation from medical school.
3. Members who have retired from active practice.

Active members of the A.M.A. are not excused from the payment of dues by virtue of their classification by local societies as "honorary" members, or because they are excused from payment of local or state dues.

The House of Delegates of the A.M.A. voted to require the payment of \$25 for 1950 also. This has resulted in a small amount of confusion, particularly from men who failed to make the payment last year, and who have not taken care of the matter this year, with the result they are not receiving the *Journal*.

Every effort has been made to explain the situation and urge payment of the 1950 membership dues.

Of the 340 paid-up members at the time our audit was made, a total of 318 had subscribed to the official publication of our association, NORTHWEST MEDICINE.

Since our audit our membership has increased. Here is the report by societies as of June 11:

Society	State	NWM	AMA
Bonner-Boundary	8	8	8
Kootenai	15	15	13
Shoshone	12	12	12
North Idaho	50	50	50
Southwestern	124	114	124
South Central	64	64	62
Southeastern	50	42	48
Bear Lake-Caribou	10	10	10
Idaho Falls	36	31	34
Upper Snake River	16	16	16
TOTAL	385	362	377

There are approximately 50 physicians known to be practicing in the state who are not members of any component society, and in turn, the state association. I would like to urge our component society officers to encourage membership for these physicians.

Two meetings of the Councilors have been held since our annual meeting last September. A brief resume of action taken at these meetings follows:

First session in Boise, January 6, 1951.

The Officers and Councilors met at a joint session with members of the association's Advisory Committee to the Department of Public Health on January 6, 1951, to discuss the various functions being carried out and planned by the Department. A complete report of this meeting will be available through the Advisory Committee to the Department.

The program for this annual meeting was outlined by Dr. Alexander Barclay, Program Chairman, and members of his committee and approved.

The matter of Legislative action was discussed with Legislative Chairman Raymond L. White.

Attorney General Robert E. Smylie gave a report on the conviction of Harold S. Bush, Priest River Naturopath, charged with practicing medicine without a license. Bush had been convicted on two counts and fined \$300 on each count. However, the fine was suspended. The action was approved.

Activities of the Armed Forces Advisory Committee were reported upon by Chairman O. F. Swindell of Boise. Action was approved.

A second meeting of the Councilors was held in Boise on May 26, 1951, at which time members of the Special Insurance Committee met with your Officers to discuss their activities during recent months. A report of this committee will be presented later.

The printed program for this meeting was approved, as was the business which had been transacted through our state office since the last meeting of the Council.

A motion to employ Mr. Robert Smylie as association Attorney on the basis of a retainer of \$600 a year was duly seconded and approved.

During the past nine months the association has been represented at a number of meetings of national importance. These included:

A Conference of Representatives of medical associations in the eleven Western States with military authorities in San Francisco, October 1, 1950, for the purpose of discussing the doctor-draft and civilian defense.

The Interim Session of the American Medical Association in Cleveland in December, 1950.

The Rural Medical Care Committee's Annual Meeting in Louisville, Ky., in March.

The Meeting of Representatives of State Armed Forces Advisory Council in Washington, D. C.

The White House Conference in Washington, D. C.

The annual Conference of State Boards of Medicine and Medical Licensure in Chicago.

In conclusion, I would like to say that it has been an honor and privilege to have served this past year

as your Secretary. Much appreciation must be directed to the office of Executive Secretary for the fine cooperation and attention to detail which has been given.

Balance Sheet As of April 30, 1951

ASSETS

CASH IN BANKS:

Continental State Bank	
(General Fund)	\$12,312.63
Idaho First National	
(Savings Account)	1,159.73
(Education Fund)	1,351.79
First Security Bank	
(Welfare Fund)	6,131.25

Total Cash in Banks	\$20,955.40
Accounts Receivable—Members	610.00

INVESTMENTS

\$18,550.00 Maturity Value Gov't Bonds	
(Idaho Medical Foundation) (Cost)	13,727.00

OFFICE EQUIPMENT

Cost	\$ 1,743.63
Less Reserve for Depreciation	544.23
	1,199.40
	<u>\$36,491.80</u>

LIABILITIES, RESERVES AND SURPLUS

CURRENT LIABILITIES

Northwest Medicine	\$ 736.00
American Medical Association	100.00
Accounts Payable	329.31

Total Current Liabilities	\$ 1,165.31
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RESERVES

Idaho Medical Foundation	\$13,727.00
Welfare Fund	6,131.25
Education Fund	1,351.79

Total Reserves	\$21,210.04
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GENERAL FUND SURPLUS

Balance, July 31, 1950	\$11,432.17
Add Net Profit—Exhibit B	2,684.28

Balance—Gen'l Fund April 30, 1951	\$14,116.45
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Total Liabilities, Reserves & Surplus	\$36,491.80
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Statement of Revenue and Expenses From August 1, 1950 to April 30, 1951

REVENUE

Dues	\$6,862.00
Welfare Dues	3,730.00
	<u>\$10,592.00</u>

Registration Income	2,226.13
Interest Earned	22.84
Refund A.M.A.	601.47

Total Revenue	<u>\$13,442.44</u>
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EXPENSES

Convention Expense	\$2,374.99
Legal and Auditing	640.00
Office Expense	443.60
Printing and Stationery	187.39
Salaries	2,069.94
Telephone and Telegraph	678.45
Traveling Expense	2,485.81
Rent	996.00
Miscellaneous Expense	714.90
Expense of Bonds	32.90
	<u>\$10,623.98</u>

Net Profit Before Depreciation	\$ 2,818.46
Depreciation—Office Equipment	134.18

Net Profit (To Exhibit A)	<u>\$ 2,684.28</u>
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**Statement of
Cash Receipts and Disbursements
General Fund**

From August 1, 1950 to April 30, 1951

CASH RECEIPTS

Dues	\$6,502.00	
Welfare Dues	3,540.00	\$10,042.00
Northwest Medicine		975.00
Dues Collected for A.M.A., Deposited in General Fund		3,025.00
Registration Income		2,226.13
Refund A.M.A. for Collection Expenses		601.47
Transfer from Welfare Fund		2,140.00
		\$19,009.60

DISBURSEMENTS

Convention Expenses	\$3,375.59	
Less Contributions to Convention—		
Anti-T.B. Ass'n	\$382.37	
Idaho Cancer Society	306.06	
Idaho Crippled Children	237.17	
Intermountain Surgical	75.00	1,000.60
Net Convention Expense	\$2,374.99	
Expense of Bonds	32.90	
Purchase—Office Equipment	401.87	
Northwest Medicine	1,186.50	
American Medical Association	2,925.00	
Legal and Auditing	640.00	
Office Expense	261.59	
Printing and Stationery	187.39	
Salaries	2,069.94	
Telephone and Telegraph	677.07	
Traveling Expense	2,485.81	
Miscellaneous Expense	566.95	
Accounts Payable—July 31, 1950	343.68	
Rent	996.00	\$15,149.69
Increase in Cash		3,859.91
Add Cash Balance July 31, 1950		8,452.72

Cash in Bank—General Fund—April 30, 1951. \$12,312.63
ROBERT S. MCKEAN, *Secretary-Treasurer*

Report of Executive Secretary

My comments will be brief, inasmuch as a good portion of the activities in which I participate as Executive Secretary have been adequately covered in other reports.

I would, however, like to take this opportunity to give my sincere and warm personal thanks to the officers and councilors, to the members of the State Board of Medicine, to the component society officers, particularly the secretaries, and to the chairmen and members of the various committees who have given me their wholehearted support during the past year and who have materially assisted me in carrying out my duties as executive secretary.

All have given freely of their time and efforts in carrying out the instructions of this House of Delegates, the functions outlined in the Constitution and By-Laws of the association, and the requirements of the Medical Practice Act.

During the past year much has been accomplished by the association, and I can vouch for the fact that more people are aware that there is a medical association in the state and that members of the medical profession in Idaho are being requested more each day to provide essential leadership in many, many activities and rightfully so.

I would be amiss not to publicly thank Dr. Scott for his outstanding leadership during the past year; Dr. McKean for his tolerance and cooperation; Dr.

Popma for his counseling and assistance; Dr. Poin-dexter for his cooperation and patience and Dr. West for his sound advice. There are many others who have generously contributed in aiding us in carrying on the operation of the state office and I am sincerely grateful for their help.

The members of the Program Committee, under the chairmanship of Alexander Barclay, have been extremely cooperative and I think are entitled to a special vote of thanks. They have worked diligently and harmoniously in arranging the program for this meeting. I am certain many of you are aware of the details that must be taken care of in planning a meeting, and none have been too small or exacting for this committee to attend.

To emphasize the work of the Program Committee I might recall that printed copies of the program were mailed to the entire membership of the association early in May—that is somewhat of a record and has established somewhat of a precedent.

There is another group of physicians in the state which has done an excellent job in carrying out the instructions of the House of Delegates and that committee is the Armed Forces Advisory Committee. O. F. Swindell, chairman of the committee, with the assistance of other members of the state committee, is doing an excellent job in carrying out the provisions of the resolution approved by this body last September. Members of component society advisory committees are to be complimented for carrying out their responsibilities in this respect, also.

Again, it is a pleasure to work with such men as Dr. Swindell and the others.

Now a word or two about the office. As you know, we have prepared nine issues of the News Letters since the last meeting. I hope they meet with your approval.

We make every effort to get the News Letters out early in the month. We were late with the March issue because we wanted to give you as much information about the Legislative session as possible.

I invite your criticisms, comments and suggestions. I hope the recent changes made in the type style meets with your approval.

I am happy to report that more of the members are using the state office. We attempt to provide service on an association basis, for the societies and for individuals alike. If we can be of help to you, please do not hesitate to let us know.

During the past year I have had the pleasure of working closely with 12 of the association's committees in which 85 physicians participate. My part of these meetings generally involves the details, yet I am offered the opportunity of sitting in on these meetings which provides me an opportunity to have a better insight into the activities of the association.

Again, the interest in association activities by the participation of 85 physicians is truly outstanding.

As Dr. White pointed out in his Legislative Committee report, we did have a busy time for nine weeks early this year. The session, to say the least, was unpredictable and, to keep abreast of some of the legislative activities, it was necessary that we maintain daily contact with friends of the association in both the House and the Senate.

Last December I had the opportunity to attend the Interim Session of the A. M. A. House of Delegates in Cleveland with Dr. Woolley, Dr. Scott and Dr. McKean. These meetings afford me an opportunity to meet officials of other state and county medical organizations, as well as men who hold positions similar to mine in other states. The amount of activity carried on at these sessions is truly amazing and if the opportunity presents itself, I heartily recommend that you sit in on one of these meetings. I can assure you that it will be well worth your time and effort.

ARMAND L. BIRD, *Executive Secretary*

Cancer Committee

Your Cancer Committee wishes to commend the physicians in the State of Idaho who are working with the local units of the Idaho State Cancer Society, a branch of the American Cancer Society, to further public knowledge of cancer. We believe that this is one of the most important projects being done for the control of cancer. Last winter 32 physicians participated in the state training schools for workers of the society.

We have no accurate count, since the annual reports are not in, but it is certain from preliminary reports that many more physicians, statewide, have spoken at public meetings this year than at any time in the past. We also know that there is much more interest being shown by the lay audience this year than ever before.

It is the Cancer Committee's opinion that every physician in the state should make himself responsible for cancer case reporting. This is not only a responsibility, but it is the law. In the first year of record keeping with the Idaho Cancer Case Register, only 59 doctors and 9 hospitals reported cases. 1,024 new cases were reported, 352 of these on death certificates.

Breakdown of figures:

- 672 patients were still alive at the time of this report.
- 293 patients were reported as having localized cancer when the physicians first saw them.
- 138 patients were reported as metastatic when first seen.
- 216 were reported as "conditions unknown or not stated."

It is your Cancer Committee's belief that many of the 293 patients who reported to their physician while cancer was still in its primary stages have done so because of the exceptional program of public education being conducted by the Idaho Cancer Society. However, this percentage is far too low and can be markedly improved.

Your Cancer Committee fails to understand why 216 patients should be reported as "conditions unknown or not stated."

There are approximately 396 physicians who did not report cancer cases as legally required by Idaho statute.

We urge that the Idaho State Medical Association and each component society encourage and stimulate its members in cancer case reporting. We urge each doctor here to visit the exhibit in the lobby of the Lodge, and pick up a supply of cards for reporting.

Professional education phase of the Idaho Division of American Cancer Society is as follows: 141 physicians have attended a week's course on cancer; another 30 will have been invited to the Sixth Annual Course in September at the University of Oregon Medical School. These men are selected by a medical committee representative of the entire state with the help of your Cancer Committee.

Twenty-eight dentists have attended postgraduate courses in oral cancer.

The cost of these projects is shared by the Idaho Cancer Society and the State Department of Public Health.

The Idaho Cancer Society has again this year sponsored one of the speakers for this meeting.

Direct aid to cancer patients has continued along lines established by your Cancer Committee and other members of the Idaho Cancer Society Medical Committee. We have resisted the use of the society's funds to subsidize physicians or hospital beds or both. We expect to continue to resist this subsidization because of the corrupting qualities of such practice. It is the Cancer Committee's opinion that the medical and hospital costs for indigent care remain in the local and state governmental agencies. We firmly believe that those who are able to pay can take care of themselves, and should not impose their responsibilities on the community.

The Idaho Cancer Society has furnished transportation to treatment centers for 49 patients at a total cost of \$2,126.40.

Room and food while patients received out-patient treatment away from home for 37 patients at a cost of \$1,846.60.

Thirteen patients have had dressings at a cost of \$527.66

Six patients have had loan equipment at a cost of \$125.28.

Twelve patients have had nursing visits at a cost of \$337.00.

Ten patients have had hormone therapy (testosterone or estrogens) at a cost of \$124.33.

A total of 192 persons have requested special services from the Idaho Cancer Society in this nine-month period. Only 87 of them received direct financial aid, but all of them used the facilities of the society for the coordination of other community resources towards the solution of the total family problem.

Your Cancer Committee recommends to the Idaho State Medical Association that at least one tumor clinic be established in the state and possibly two; these tumor clinics to be set up and operated under the standards set forth by the American College of Surgeons. We strongly urge the Idaho State Medical Association to encourage and support such a facility wherever the necessary staff is available.

Your Cancer Committee solicits your suggestions, comments and recommendations toward increasing the usefulness of Idaho's program of cancer control; one program jointly undertaken by the Idaho State Medical Association, the American Cancer Society's Idaho Division, the Department of Public Health, and uncounted thousands of lay workers and contributors.

CHARLES A. TERHUNE, *Chairman*

The report was unanimously approved.

Welfare Committee

The Committee met on January 20, 1951, at the executive offices of the Idaho State Medical Association. Members present were Robert S. McKean, Hoyt B. Woolley, C. B. Beymer and Manley B. Shaw. E. V. Simison and W. S. Douglas were unable to attend. O. F. Swindell was with an emergency case and was unable to attend.

No new legal actions of malpractice nature were brought before the committee.

It is the consensus of opinion of this committee that welfare committees on the local component society levels should be formed and that these local societies should take local action on all grievances of the public or between the doctors.

Only written requests for intervention by the state committee regarding the matters should be reviewed by the state committee; also, that all actions regarding malpractice suits against doctors should be reviewed directly by the Welfare Committee rather than go through the component Society Welfare Committee in order that a coordinated awareness of such activities can be had at a state level.

Since the meeting it has been suggested by several members of the committee that the local component welfare committees send regular reports regarding their activities to the state committee so that it may be aware of what is going on as far as public grievance or doctor-doctor grievance is concerned.

The following is a statement of the finances of the Welfare Committee and itemized account of the expenditures of the committee for the past year:

1/1/50 Cash on hand	\$8,571.25
4/6/50 E. B. Smith for professional services	300.00
10/20/50 Idaho State Medical Association refund from Welfare Committee	2,140.00
12/31/50 Cash on hand	\$6,131.25

It has unofficially come to the attention of the committee during the past month that two specific complaints by the public against over-charge have been

made. These have not been formally presented to any local welfare committee nor to the state committee so far as we know.

It is our feeling that these matters should be looked into by the local Welfare Committee and that if not settled or solved at that level, should be referred to the State Welfare Committee.

Amendments to the State Constitution and By-Laws in order to outline the additional duties of the State Welfare and Grievance Committees are as follows:

(Full text of the resolution appears in Report of the Resolutions Committee.)

Since the committee report was prepared additional information of serious importance has come to this committee. Specifically, it is now well known, we believe, that the passage of the Osteopath Bill was a vote against the doctors and not a vote for the osteopaths. The prime consideration of the Legislature in passing the bill seems to be the doctor's inattention to emergency calls and the problem of overcharging. This certainly has a direct bearing on the relations of the Welfare and Grievance Committee and we would urge that all societies take immediate action to form their grievance committee on a local level and begin handling the problems which are in fact acting to the detriment of the profession at large.

In addition, it has come to the attention of the chairman of the committee that a malpractice threat as the result of a surgical mistake has been settled by the doctor concerned and the Aetna Casualty Company. This was called to our attention by the Surety itself and not reported by the doctor.

I wish to call your attention to the fact that this matter was not brought to the attention of the Welfare Committee as required by our State Constitution. If the Welfare Committee is to be of service to the profession, it certainly behooves the members of the State Medical Association to make such information available and report threats of malpractice and malpractice action promptly at their occurrence, otherwise this chairman can see no point in the committee's existence.

A letter from Mr. E. E. Midgley of the Aetna Casualty & Surety Co. on the matter of malpractice claims was read by Dr. Shaw. Copies of the letter are available through the Executive Offices.

M. B. SHAW, *Chairman*

The report was unanimously approved.

Legislative Committee

All of you are aware that the Legislative Committee of the Idaho State Medical Association had more than a busy time during the 31st session of the state legislature this year.

Our activities principally revolved around two naturopathic measures and an osteopathic bill.

The two naturopath bills were killed without the benefit of introduction on the floor of the Senate and the osteopath bill, as all of you know, was passed by both houses and finally vetoed by the Governor.

The first of the two naturopath bills was presented to the Senate Public Health Committee during the second week of the session. Senator David Tate of Boise, chairman of the Public Health and Welfare Committee, provided us with a copy of the measure within a matter of hours after the bill was presented to his committee.

Thus began a series of hearings before the Senate Committee at which time the committee vigorously opposed the proposed bill. The Senate Committee voted to kill the bill after the hearings.

A few days later a second naturopath bill was presented to the committee. It was sponsored this time by several local naturopaths and two imported from Ohio. We again opposed the measure and again the committee refused to approve the bill.

A second and larger project was the eventual defeat of the proposed osteopath practice act (House Bill

No. 30) which was introduced in the House by a number of representatives.

The House Public Health Committee, after several requests from our committee, granted us a hearing at which time we expressed opposition to the bill. But following the hearing, the committee recommended that it "do pass" and shortly thereafter the bill passed the House with a substantial majority.

In the Senate, before the Public Health and Welfare Committee, we expressed opposition to the bill and, after a ten-minute hearing, this committee—which had done such an admirable job on the naturopath bills—voted the bill out with a recommendation that it pass, although a bare majority of the committee members were present at the time the measure was approved, and the chairman refrained from voting.

All of you are aware of the considerable amount of pressure which was brought to bear against the measure; a relative amount of support for the bill was sponsored by the osteopaths.

On the first Senate roll call on the bill, it was defeated by a vote of 20 to 19. Senator Earl Wright of Clark County, who had voted against House Bill No. 30, served notice that he would ask for reconsideration of the vote by which the bill was defeated.

An hour later the Senate reconsidered the bill and the roll call resulted in a tie vote of 21 to 21. Lieutenant Governor Edson Deal, who had pledged himself against the measure, broke the tie and voted in favor of the osteopath bill.

We had lost our battle to defeat the osteopath bill.

Governor Len Jordan vetoed the bill after a hearing which was attended by members of the Legislative Committee and President Russell Scott. His reasons for vetoing the measure were based essentially on technical grounds. It was a very poorly drawn piece of legislation and contained many inaccuracies.

A number of other measures were considered by the Legislative Committee, including the Nurse Practice Act, several bills pertaining to workmen's compensation, the transferring of the State Tuberculosis Hospital at Gooding to the jurisdiction of the State Department of Public Health, new legislation regarding the committal of persons to the State's Mental Hospitals and a bill empowering the State Department of Public Health to regulate and standardize communicable disease control regulations, but leaving enforcement to county officials.

This last law came as a direct result of a recommendation made by the association's Medical Advisory Committee to the State Department of Public Health several years ago which was approved by this body as a resolution. This was a constructive piece of legislation which certainly reflects favorably upon the State Medical Association.

Representatives of the state association were asked by Governor Jordan for help and guidance in the preparation of his budget message regarding funds for the State Department of Public Health. Several conferences were held which resulted in a complete re-evaluation of all funds requested by the department and which were left at the previous biennium level by an economy-minded legislature.

At the hearing we attended during the legislative session certain commitments were made by the Legislative Committee which involve the State Medical Association. We received a number of requests from two legislators for a good basic science law, and your committee was requested to present such a bill for introduction at the next regular session.

The request for a basic science law was brought about primarily during the hearings regarding the proposed naturopath law. The naturopaths were making their seventh attempt since 1923 to secure a licensing act.

An interesting sidelight on naturopaths was the conviction of Harold Priest, River Falls, Wis., naturopath, on two charges of practicing medicine without a license. Bush was found guilty on both charges by the Eighth

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Judicial District Judge E. V. Boughton of Coeur d'Alene.

It is anticipated that the conviction will be appealed to the State's Supreme Court and we are hopeful of receiving a favorable decision. However, some further control must be effected to maintain basic scientific knowledge of those who would practice any of the healing arts in which the responsibility for diagnosis and treatment rests with the licentiate.

The Legislative Committee, therefore, would like to present the following resolution on the matter of a Basic Science Law.

(Full text of the resolution appears in Report of Resolutions Committee.)

Several years ago the Legislative Committee was requested to study and introduce into the legislature a bill designed to further investigation of deaths of persons occurring under circumstances of suspicion, or when not under the direct care of a physician. This request was brought about by the appearance on our association's program of Dr. Alan Moritz of Harvard. During recent years, Idaho's laws on this matter have received national attention in lay publications. Inasmuch as no definite resolution or action has ever been undertaken by the association, the Legislative Committee wishes to submit the following resolution:

Whereas: The Idaho State Medical Association is the recognized body of scientific medical leadership in Idaho, and

Whereas: The citizens and the legislature look to the Idaho State Medical Association for leadership in recognizing and solving medical problems affecting the population, and

Whereas: Eminent national medico-legal authorities and widely read and distributed national periodicals have pointed out to the nation and to the citizens of Idaho that many deaths occur in our state each year which are not properly investigated as to the actual cause by adequate postmortem examinations by competent, specially-trained medical personnel, and

Whereas: Death from unknown cause may serve to prevent the early detection of epidemic diseases, may prevent the detection of early contagious disease in living persons who were in contact with the deceased, and may obscure crime of serious nature and serve to classify death as accidental that may be due to disease or other cause, and

Whereas: The existing statutes of Idaho do not provide for competent thorough medical examination of persons who have met death from causes unknown by disease, supposed accident, or other forms of trauma, and

Whereas: Sufficient qualified pathologists to act as medical examiners now practice and reside in Idaho or are available to Idaho from nearby states, and

Whereas: Laboratory facilities of the Idaho State Department of Public Health are adequate to perform toxicological tests, and

Whereas: There exists an urgent need for the establishment of the medical examiners system in Idaho for the protection of the public,

Therefore: Be it resolved, that the Idaho State Medical Association assume its responsibility for the establishment of a medical examiners system in Idaho by a thorough study of the problem of unexplained deaths and prepare the necessary statutes for submission to the next regular session of the State Legislature. Be it further

Resolved: That copies of this resolution be sent to the Governor of the State of Idaho, the Lieutenant Governor and the Attorney General.

Your Legislative Committee strongly recommends that each member of the medical profession in the state appoint himself as a committee of one to maintain close contact with persons who seek elective offices in the state—particularly those seeking seats in the State Legislature next fall.

Informing candidates in the primary election as well as in the general election of medicine's stand in many affairs is of utmost importance.

We have helped to set up a very effective organization on a national basis for educational purposes, but we have been negligent on the state and local level where much remains to be done. We stand to lose much by being dormant in the state while we are being alert on a national basis.

Better methods of informing the membership of the Legislative Committee's activities are being devised. Better methods of screening proposed legislation are being studied and planned.

No plan of action can work better than a legislature which is sympathetic toward the betterment of the health of the people of Idaho.

RAYMOND L. WHITE, *Chairman*

The report was unanimously approved.

Medical Advisory Committee to State Department of Public Assistance (Eye Care)

This report covers the period July 1 to December 31, 1950, and January 1 to March 31, 1951 (fourth period not yet complete and cannot be reported).

Total number of cases, 808. Cost, \$20,322.81, with breakdown as follows:

	Cases	Cost
Examinations	694	\$ 4,378.00
Medical	36	424.39
Surgical	57	6,945.00
Hospital	83	8,085.17
Glasses	34	455.95
Prostheses	4	46.30

It is to be noted that only 34 cases had glasses supplied and these are all people who have had cataract extraction. However, of the cases cared for, 126 had glasses supplied through community effort and 130 with family assistance. The policy of your committee remains as heretofore: Glasses will be supplied after all other resources have been found inadequate.

In addition to the above, Rehabilitation Service was rendered in 48 cases costing \$1,774.30 and of this amount \$843.83 was paid to hospitals and \$625 surgical and glasses \$97.72.

Surgical Report:

Cataract Extractions	38
Vision restored in 15 and improved in 17 cases. Further loss reported as prevented in 2 cases and no benefit in 4 cases.	
Muscular Anomalies	17
Glaucoma	1
Miscellaneous	11

Your committee again wishes to express thanks to the Medical Referee who carefully scrutinizes all cases before operation and on occasions offers suggestions as to treatment from the fund of his vast experience.

WALLACE BOND, *Chairman*

The report was unanimously approved.

Teachers Examination Committee

There have been no meetings of this committee inasmuch as there have been no problems presented for our consideration. To my knowledge this committee has not been consulted by the State Board of Education or by the State Teachers Association. It is my impression that this committee has an advisory capacity and that, unless we are called upon to act, we have no function.

S. M. POINDEXTER, *Chairman*

The report was unanimously approved.

State Board of Medicine

The State Board of Medicine has had but one session for the purpose of granting licenses to physicians since the last meeting of the House of Delegates.

This meeting was held in January, at which time 22 physicians applied for licensure without examination and four candidates wrote the examination.

Addition of 26 licenses granted brings the number of physicians licensed to practice medicine and surgery in Idaho to 773. A survey made by our office staff indicates that between 440 and 450 of the licensed physicians are currently practicing in the state.

Since July 1, 1949, when our Medical Practice Act went into effect, a total of 105 physicians have been licensed. During the corresponding two-year period of 1947-49 a total of 103 physicians were licensed. It is obvious that there is no increase in the number being licensed under the new act.

For the benefit of new members of this House, I would like to mention that the board maintains a joint office with the state association and that the board contributes a large portion of the financial support for this office.

All of our expenditures are controlled by the State Board of Examiners, consisting of the Governor, the Attorney General and the Secretary of State, whose responsibility it is to approve expenditures of state funds, including the State Board of Medicine.

State Board of Medicine books and accounts have recently been audited. I have a complete copy of the Audit Report with me in event any of you wish to see it. Here, briefly, is a summary of that report.

The balance in our fund as of July 1, 1950, amounted to \$8,012.75; receipts from that time until April 30, 1951, totaled \$5,938.00 for a total of \$13,950.75.

Source and amount of revenue is as follows: License renewals, \$850; licensure fees, \$4,874; temporary licenses, \$85; examination fees, \$125, and certification fees, \$3.

Our total expenditures during this period amount to \$8,180.12, leaving us an unexpended balance, as of June 1, 1950, of \$5,741.42.

As many of you know, we are currently engaged in license renewals and the revenue from this activity at this particular time has not been tabulated.

Last week we received an opinion from the Attorney General in which he states that physicians and other professions licensed in the state will not be required to pay the yearly license renewal fee as long as they are on active military duty.

This information will be included in detail in the next issue of the News Letter and license renewals received from physicians currently on duty will be returned with an appropriate letter of explanation.

You all recall the conviction of Harold V. Bush, Priest River naturopath, last December on two charges of practicing medicine before District Judge E. V. Boughton of Coeur d'Alene. Mr. Bush was fined \$300 on each count with \$400 of the total fine suspended.

Notice of appeal to the State's Supreme Court has been filed. However, the processing of the appeal has been delayed because Bush's attorney withdrew from the case.

It is anticipated, however, that the appeal will be carried through inasmuch as new counsel has appeared for Mr. Bush.

We have received reports that Bush has continued some of the activities which led to his arrest and subsequent conviction. The board, therefore, at its last meeting asked that proceedings be instituted under Section 15 of the Medical Practice Act to secure an injunction against Mr. Bush for continuing his practice.

An investigation necessary prior to filing this suit has been completed and the temporary injunction should be issued some time within the next two or three weeks. Because of this pending legal action, which may well determine the constitutionality of our act, the board has withheld legal action on other cases.

Additional information on legal actions will be reported to you through the News Letter.

The State Board of Medicine was represented at two meetings of national importance. W. B. Ross, vice-chairman of the board, and myself attended the Forty-Seventh Annual Congress on Medical Education and

Licensure, and the Twenty-Fourth Annual Meeting of the National Conference on Medical Service in Chicago in February.

I would like to take a moment to express the sincere appreciation of members of the board to the members of the profession in Idaho. You have all been very cooperative to us in our efforts to carry on our activities as described in our Medical Practice Act. We trust that we will continue to merit your support and cooperation.

I would also, at this time, like to pay tribute to the members of the board. All of the members have served you to the very best of their ability. I especially want to mention Harwood Stowe of Twin Falls, who was replaced at the expiration of his term as a board member by Reed J. Rich of Montpelier. Dr. Stowe has rendered an outstanding service to the profession in his membership on the board. We will miss him, of course, and it is my pleasure to welcome Dr. Rich to our official family.

I want, also, to express the appreciation of the board to the members of our staff, Mr. Armand Bird, executive secretary, and his secretary, Miss Elsie Roff, for their continued efficiency and cooperation.

S. M. POINDEXTER, *Chairman*

The report was unanimously approved.

Advisory Committee to Department of Public Assistance

The activities of the committee appointed at the last year's session to consult with and advise the Department of Public Assistance on matters of mutual interest in the conduct of that department have been largely exploratory to date. A great deal of orientation on the part of members of the committee with regard to functions of the department and problems peculiar to administration has been and will continue to be necessary.

It is obvious to all in the profession that one of the serious problems confronting the Department of Public Assistance, as well as other agencies of government, local and state, is the administration of a program of medical care that will be acceptable to the patient, that will be compatible with the judgment of the medical profession as good care, that will be acceptable to the general public and, above all, will be financially possible.

While the problems involved in any plan to bring indigent medical care in Idaho to a higher and more consistent level are many, due to the great area involved, the varying population, climatic and occupational diversities, one of the first problems to be solved is the adoption of uniform standards throughout the state. Standards of financial eligibility as ascertained by personnel trained in social welfare and administration, standards of medical eligibility, while no less important, will not be so difficult to establish. Of equal importance is the maintenance of adequate social and medical records, both being essentially absent in most segments of the state at the present time.

Two years ago Payette County, through its commissioners, enlisted the aid of the department in administering its indigent program. The money raised in the county through levy was turned over to the Public Assistance Department who investigated all claims for medical aid and made authorizations and disbursements according to their records.

This embodied many of the above-stated requirements, that is adequate investigation of the claims and claimants, by a staff trained in social welfare and cognizant of the many facets to each problem presented. After the claim was judged to have met the standards of eligibility, authorization was issued and this was another desirable feature, the patient went to the physician of his choice. While we do not imply there have been no problems since the adoption of this plan, it has worked well as far as the money available permitted.

Just after activation of this committee the department, through its commissioner, advised the committee that other counties had approached the department with the idea they administer their program in a similar manner and asked the committee to review the standards previously set in Payette County. In addition the committee was asked to consider another possibility. Since the passage of the Amended Social Security Act by the Congress in 1950, certain funds were available to indigent citizens of Idaho for medical care through the department, provided that the standards in operation throughout the state were uniform. This, then, would have augmented the funds available to the department and to individuals or families on the roles of the department in which medical care became necessary, authorization was provided and payment made out of these newly acquired funds.

All phases of this possibility were considered and standards of eligibility were re-defined and a modus operandi outlined for presentation to each of the component societies of the State Association. This was planned for December and early January of this year so that the department could make application in its budget for the additional expenditures this plan, if approved by the medical society, would entail by way of additional case workers and clerical help. The possibility was raised in committee sessions that the plan might not meet with favor, in spite of many obvious advantages, since it entailed accepting federal grants-in-aid. The department countered that should this be true they would mean probably more pro-rated payments to the physicians and hospitals. These alternatives, too, were to be presented to the individual societies, when the plan as a whole was ready. The committee and the department envisioned this as a possible program by which all indigents, not simply those covered by the department, could be eventually brought in through the cooperation of the counties such as that in Payette County, or with enabling legislation, the creation of a fund for indigent care throughout the state by channeling the mill levy to this one fund, thus cutting out much duplication of expenses of administration in each county, as well as making more money available in the more populous areas where the need is much greater. The committee in this report would like to make it clear that, while this was a state-wide plan to be administered by a single department, it was not to be completely centralized, but for speed and facility, the functions were to be carried out by the field offices and medical consultants assisting in these functions were to be nominated by the local medical society in that area.

No such plan has been presented, as you all know. Due to the increase in federal taxes and the election of a state administration which seemed to realize that this would further pre-empt the sources of state revenue, it became obvious that the department was going to be hard pressed to maintain its previous budget or carry out its most basic responsibility of aid to the blind, the dependent children, old age recipients and the totally and permanently disabled, and would be unable to enter into this plan at this time, with or without the federal grant-in-aid.

Further possibilities beyond those mentioned above would be some insurance plan to which the department could subscribe for each person, or family, on their roles, and possibly counties could do the same. The question would then be to find a carrier who would cover these individuals at a premium the agency or county could pay, since these individuals probably represent a greater risk and a higher utilization ratio. If there were a Blue Shield Plan in Idaho this problem might be alleviated somewhat as far as purely physician costs are concerned, as we know the profession would accept greatly reduced pro-rata payments if it would spread the load and make free choice of physician available to the patient. Hospital costs are another matter and no information is or will be available until some plan is inaugurated on a trial and error basis.

In summary, the committee has gained considerable insight in the problem of medical care for the indigent. From an abstract point of view, we believe there is merit in the plan discussed here in some detail, particularly as a trial balloon, and in reality is pretty nearly the only direct contribution we as a group can make as far as inaugurating a plan aimed at eventual comprehensive medical care to the indigent is concerned. We especially are impressed that this is a problem which affects all society and in the end is to require some governmental aid, and we believe that is more ideally state and county aid rather than federal.

It is the specific request of the Department of Public Assistance, communicated through the chairman, that the committee be maintained for future assistance and consultation.

C. L. HOLMES, *Chairman*

The report was unanimously approved.

Armed Forces Advisory Committee

The association's Armed Forces Advisory Committee was formulated in accordance with Resolution No. 7 as approved by this body at our annual meeting in September, 1950.

The resolution called for the establishment of state and local society advisory committee to work with the Selective Service System and the various branches of the armed forces.

The resolution also called for each component society in the state association to elect one member for each 25 society members or major fraction thereof. This resulted in the election of 24 local society members. From this group one member of the state committee was elected from each of the four councilor districts and I was elected by this group as state chairman.

In further accord with the resolution, copies were sent to the respective heads of the Army, Navy and Air Force, the Governor and other officials.

The meeting for the purposes of electing the membership of the State Armed Forces Advisory Committee was held in offices of the association in Boise on October 21, 1950.

The other members of the state committee elected include:

Councilor District No. 1—Clifford O. Armstrong of Moscow.

Councilor District No. 2—Fred A. Pittenger of Boise.

Councilor District No. 3—Charles A. Terhune of Burley.

Councilor District No. 4—Harvey Guyett of Idaho Falls.

While we were in the process of forming our committee, the National Advisory Committee was appointed by President Truman with Howard A. Rusk of New York City as chairman.

Copies of our resolution were sent to officials of the Idaho State Dental Association as well as the Idaho State Veterinary Medicine Association.

Provisions of Public Law 779—the Doctor Draft Act—called for the establishment of state and society advisory boards much in the same manner as our original resolution, however, it was required that the State Armed Forces Committee also include representatives of the dental and veterinary medicine profession and public health.

The result was that four dentists were recommended to our committee by the dental association, two from the veterinary medicine association and one from the State Department of Public Health.

Thus our five-man committee grew to be a committee of 12.

The members of the state committee are as follows: Myself, Dr. Armstrong, Dr. Terhune and Dr. Guyett, representing the medical association. C. R. Fox, Twin Falls; R. C. Peterson, Lewiston; Merle Kirkpatrick, Caldwell, and G. B. Crabtree, Idaho Falls, representing the dental profession. Arthur P. Schneider, Boise, and

Bernard Copple, Boise, representing the veterinary medicine profession. Mr. L. J. Peterson, Boise, administrative director, Idaho Department of Public Health, representing Public Health.

The names of the state committee were sent to Washington and appointments were made by Dr. Rusk. Apparently this action was necessary to make the committee's functions official.

In the meantime, a rather lengthy questionnaire was prepared and sent to each physician known to be practicing in the state. A total of 494 were mailed and we received approximately 425 back. These questionnaires have played a vital role in cases submitted to the board for consideration.

On October 16, physicians who had not had military service or who had been deferred from service because they were in training, and those physicians who received some part of their medical education through governmental sources were required to register. A total of 36 registered at this time.

I might emphasize at this point that the state and local committees have no legal jurisdiction. We serve in an advisory capacity only, and our recommendations are subject to official recognition or non-recognition at other levels.

On November 1, the first case was referred by members of a local system to the committee. The case was in turn referred to members of a local society, who made recommendations to the member of the state committee in the particular councilor district.

Our recommendation on the first case handled was not heeded by a local draft board. The committee had declared the physician non-essential and had recommended a 1-A classification. However, the local draft board under whose jurisdiction the man was registered, saw fit to ignore our recommendation and placed the man in a 2-A classification and granted a deferment for six months. I might add that the case

was referred to us again and our recommendation of non-essential was accepted by the draft board. We presume the physician has applied for a commission and will be called up for military service shortly.

Since that time the committee has handled a total of 19 cases with disposition as follows: Recommendations for limited deferment, 2; indefinite deferment, 2; 30 to 60-day deferment, 2; no deferment, 8; action still pending, 3.

Three dental cases have been handled by the state committee with none being recommended for deferment.

Several Navy Reservists were called to active duty. However, their cases have not been handled through the committee.

I would like to point out that each case is handled as a separate function. Every effort is made to utilize members of the local society committee to the fullest extent. It is not the intention of members of the state committee to "put the finger" on any physician, dentist or veterinarian. All of the decisions of our committee can be appealed to the Appeal Board of the State Selective Service System or to proper military authorities. I am somewhat pleased to report that to our knowledge no appeals have been made to date.

The Second Registration Day for physicians was on January 15. At this time physicians who had received discharges from the Armed Forces or who had been declared physically unfit for military duty in World War II, or who were under 50 years of age were required to register. Physicians who hold reserve commissions in any of the branches of the Armed Forces, of course, were exempt. A total of 196 registered in the state.

Other than Navy Reservists who have been called back we know of no physicians in Priority II or III who have been called up for duty.



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There is one additional point which I would like to make and that is to urge those who are called up for military duty to let us know when they leave. This information will materially assist us in closing the case and will also assist the state office in licensure as well as association activities.

O. F. SWINDELL, *Chairman*

The report was unanimously approved.

Civilian Defense Committee

The committee is made up of the following men representing their respective areas: J. B. Morris, Boise; Lester Shupe, Caldwell; H. C. Turner, Pocatello; Dauchy Migel, Idaho Falls; Fred Kolouch, Twin Falls; James Hawkins, Coeur d'Alene; Robert Staley, Kellogg; J. H. Bauman, Lewiston, and V. J. Reynolds, Boise, chairman.

An outline guide for medical associations in the medical aspects of Civilian Defense Planning was sent to each member of the committee in the fall of 1950. It was suggested that they encourage the development of some plan such as this coordinating with the local defense program.

A follow-up inquiry brought reports from five of the eight areas. Each report revealed definite thoughtful organization and, above all, real enthusiasm. However, no uniformity in the developments occurred.

It has been only within the last two months that the Governor has started his appointments in the development of the State Civil Defense Organization. As yet, no well-defined medical plan has been presented for the various areas to follow.

If a catastrophe occurs, the paramount early need most likely will be medical. Therefore, we must be prepared. Failure of state plan is not a good excuse. We must develop the best possible working plan and present it to the state for what it is worth to them. It is the Idaho State Medical Association's chance to show the people of our state we are out in front offering our services in such emergencies.

A resolution is presented to the delegates that the Idaho State Medical Association endorse the four recommendations as set forth below and support the committee in its endeavors to carry out the proposed program, which program will be subject to the review, correction, and revision of the executive council of the state association.

a. That there be a division of the state into definite areas with a committee member supervising the medical aspects. These areas should coordinate with the state division.

b. That there be a definition of the parts, activities or phases incorporated in the Idaho State Medical Association organization for the Civil Defense as limiting it to organization and assignment of doctors and their fulfilling of these duties.

c. That there be a development of a uniform organization or plan to be adapted to each area.

d. That there be a provision by the Idaho State Medical Association of an educational program to be presented in each area at the expense of the Idaho State Medical Association if the state will not finance it.

VERNE J. REYNOLDS, *Chairman*

The report was unanimously approved.

Veterans Committee

The Veterans' Committee has been mainly concerned with a study of the fee schedule for medical services in the State of Idaho as set up in the 1950 contract between the Idaho State Medical Association and the Veterans' Administration. Members of the Committee reviewed the 1950 contract, and a number of suggestions to correct inequities in the schedule were made. The advice of other members of the Medical Association, who were not members of the Committee, was also obtained.

Suggested changes in the schedule were incorporated in a new schedule for 1951. This has been submitted to the Veterans' Administration for its approval, and is now under consideration in Washington, D. C. A list of proposed increases in the Veterans' Fee Schedule is attached to this letter.

When the Idaho Veterans' Fee Schedule is compared with similar schedules in effect in Wyoming and Montana, it is apparent that the Idaho schedule is slightly more favorable than the schedules of these two neighboring states. It is true that many of the fees allowed by the Veterans' Administration for surgical services appear low by the standards of ordinary practice in Idaho. This schedule of fees seems, however, to prevail nationally for low income groups, judging from the Veteran and Industrial Accident schedules which are available.

A justifiable criticism of the Veterans' Fee Schedule has been that, while it sets forth charges for medical services which are truly minimal, it tends to establish standard fees for patients in private practice. The Veterans' Committee has tried to raise certain allowances which were standard in the past in an effort to bring the fee schedule more in line with charges appropriate for private patients in Idaho. It is not known yet whether or not the Veterans' Administration will agree to these increases.

I wish to thank the members of my committee for their excellent cooperation in carrying on our study of the Veterans' Fee Schedule this year.

ROBERT S. SMITH, *Chairman*

The report was unanimously approved.

Advisory to the State Department of Public Health and Crippled Children Society

Two meetings have been held with the State Department of Public Health (Jan. 6, 1951, and June 18, 1951) and one with the Crippled Children's Society of Idaho.

At the January meeting, discussion was held on the following:

1. Basic Health services as compared to specialized activities. Emphasis was placed upon the establishment of the six basic health services in all areas of the state. The essential basic services are communicable disease control, maternal and child health, sanitation, vital statistics, health education, and laboratories. The Department is also faced with the establishment of special programs as grants-in-aid funds are received. These programs include venereal disease, tuberculosis, cancer, mental health, industrial hygiene, water pollution, dental health, heart disease, and specialized activities in maternal and child health.

2. Recommended procedures for immunization practices, standardization of these procedures throughout the state was advised. Letters urging that each child be immunized will accompany photostatic copies of the birth certificate to the parents.

3. Standard communicable disease regulations.

4. Fluoridation of public water supplies.

5. Sub-committee on pediatrics and obstetrics.

6. Revision of pamphlet on venereal disease.

7. Publication of "Medical Notes."

8. Mobile x-ray unit.

9. Chest x-ray requirements for health certificate.

10. Cardiovascular committee and the newly organized Idaho Heart Association.

11. Cancer case register.

The Committee approved in general the Health Department activities in the above categories.

At the June 18 meeting, the Committee approved the Department's rules and regulations for communicable diseases and the sub-committee on pediatrics and obstetrics.

The problem of disease reporting was again reviewed. The Committee passed a motion recommending that the Department of Public Health contact each



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component society for the purpose of discussing reporting procedures and that each physician be advised by letter of reporting requirements.

The Committee met with Mr. Kenneth Thomas, representative for the Crippled Children Society of Idaho on June 18, 1951.

Mr. Thomas outlined their plan for establishing a center in Boise for the treatment of Cerebral Palsy children. The plan is statewide. It consists of educational programs for parent group, speech therapy, physio-therapy, occupational therapy, and psycho-therapy for the children.

Mr. Thomas asked for recommendations from the Committee and support of the program by physicians throughout the state.

Members of the Committee are C. A. Terhune, W. R. Hearne, R. L. Peterson, J. K. Burton, H. Tremaine and O. F. Swindell.

O. F. SWINDELL, *Chairman*

The report was unanimously approved.

Cardiovascular Committee

The Cardiovascular Committee held one meeting during the past year. This meeting was held in Boise, on Dec. 10, 1950, with the following members present:

George E. Brown, Jr., Maurice Burkholder, Richard P. Howard, Henry A. Smith, Luther Thompson and the Chairman, Mr. L. J. Peterson and Terrell O. Carver of the State Health Department were also present.

There was a brief discussion of cardiovascular clinics and chest x-ray surveys. The committee approved mass chest x-ray surveys. The meeting was devoted largely to the discussion of the organization and projected activities of the Idaho Heart Association, which the committee has sponsored.

Officers elected to Idaho Heart Association June 2, 1951: President Geo. E. Brown, Jr., Twin Falls; President-Elect Burton Stein, Lewiston; Vice-Presidents Richard P. Howard, Pocatello; Harvey Hatch, Idaho Falls, and O. F. Swindell, Boise; Secretary Glenn Voyles, Twin Falls, and Treasurer Mr. William Goodall, Boise.

PAUL F. MINER, *Chairman*

The report was unanimously approved.

President Scott announced the next meeting of the House of Delegates would be held at 8:30 a. m. in the Opera House. The House of Delegates recessed until Monday, June 18.

Second Meeting of the House of Delegates

Monday, June 18
Opera House

The meeting was called to order by President Scott. Roll call showed a quorum was present.

President Scott called for the report of the Nominating Committee and Chairman Donald K. Worden presented the following candidates for election to offices of the association: President-Elect Wallace Bond; Secretary-Treasurer, Robert S. McKean; Councilor, First District (three-year term), Alexander Barclay, Jr.; Councilor, Fourth District (three-year term), E. Victor Simison; Delegate to the A. M. A. (two-year term), Hoyt B. Woolley; Alternate Delegate to A. M. A. (two-year term), Raymond L. White; Program Committee (three-year term), Frank L. Fletcher; Trustee to NORTHWEST MEDICINE (to fill unexpired term of John T. Wood), (two-year term), Doyle M. Loehr; Trustee to NORTHWEST MEDICINE (two-year term), Walter R. West; Councilor, District Three (to fill unexpired two-year term of Dr. Bond), Charles B. Beymer.

Dr. Worden moved that the report be accepted, the motion was seconded by C. C. Wendle and unanimously approved.

President Scott then called for a voice vote on the election of the new officers; there being no dissenting votes, he declared the officers elected and instructed the Secretary to cast a unanimous ballot for the ticket.

The report of the Resolutions Committee was called. Frank L. Fletcher, Chairman, reported as follows:

Report of Resolutions Committee

Resolution No. 1 CIVILIAN DEFENSE

Whereas: The need for a Civilian Defense Committee in the Idaho State Medical Association has been noted by the Officers and Councilors, and

Whereas: A committee was appointed last year but the functions therefor were not outlined, now therefore be it

Resolved: That the Idaho State Medical Association hereby proposes the following recommendations for the guidance of the Civilian Defense Committee in its endeavors in carrying out such a program, and that the program be subjected to the review, correction and revision of the Officers and Councilors at their discretion.

1. That for the purposes of administering a statewide Civilian Defense Program, the four Councilor Districts be utilized with committee members supervising medical activities.

2. That the Civilian Defense Committee be limited to organization and assignment of physicians and their fulfilling of these duties.

3. That an education program be presented in each of the areas of the state by members of the Civilian Defense Committee.

Dr. Woolley moved that Resolution No. One be approved. Dr. Worden seconded the motion which was unanimously approved.

Resolution No. 2 MEDICAL EXAMINERS

Whereas: The Idaho State Medical Association is the recognized body of scientific medical leadership in Idaho, and

Whereas: The citizens and the legislature look to the Idaho State Medical Association for leadership in recognizing and solving medical problems affecting the population, and

Whereas: Eminent national medico-legal authorities and widely read and distributed national periodicals have pointed out to the nation and to the citizens of Idaho that many deaths occur in our state each year which are not properly investigated as to the actual cause by adequate post-mortem examinations by competent, specially trained medical personnel, and

Whereas: Death from unknown cause may serve to delay the early detection of epidemic diseases, may prevent detection of early contagious disease in living persons who were in contact with the deceased, and may obscure crime of serious nature and serve to classify death as accidental that may be due to disease or other causes, and

Whereas: The existing statutes of Idaho do not provide for competent thorough medical examination of persons who have met death from causes unknown by disease, supposed accident, or other forms of trauma, and

Whereas: Sufficient qualified pathologists to act as medical examiners now practice and reside in Idaho or are available to Idaho from nearby states, and

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Whereas: Laboratory facilities of the Idaho State Department of Public Health are adequate to perform toxicological tests, and

Whereas: There exists an urgent need for the establishment of the medical examiners system in Idaho for the protection of the public, therefore, be it

Resolved: That the Idaho State Medical Association assume its responsibility for the establishment of a medical examiners system in Idaho by a thorough study of the problem of unexplained deaths and prepare the necessary statutes for submission to the next regular session of the State Legislature. Be it further

Resolved: That copies of this resolution be sent to the Governor of the State of Idaho, the Lt. Governor, and the Attorney General.

Dr. Bond moved that Resolution No. Two be adopted. Dr. West seconded the motion and the resolution was unanimously approved.

Resolution No. 3 WELFARE COMMITTEE

Amendment to the By-Laws.

Amending Chapter XV, Article II, Paragraph 4, which shall read:

The name of the committee shall be retained as the Welfare Committee.

4. Whenever this committee is informed that a claim of malpractice is made or threatened, the Chairman or Secretary shall, as soon as possible, summon a meeting of the committee for the purpose of investigating the circumstances connected with the case. *Stenographic minutes shall be kept at all meetings at the discretion of the Welfare Committee.*

(Items 5, 6, 7, 8, 9, of Chapter XV, Article II shall remain unchanged)

(New Items)

10. Each component society shall form a Welfare Committee to handle ethical and public relations problems in its area. Reports shall be sent to the State Welfare Committee at six-month intervals.

11. The State Welfare Committee, in addition to its duties as outlined, shall consider all written appeals of component society Welfare Committees, regarding doctor-to-doctor relationship, all other ethical problems and patient-doctor problems.

A motion was made by Dr. Woolley that the amendment to the association's by-laws be approved. Dr. Nelson seconded the motion and the vote to approve the resolution was unanimous.

President Scott announced that the By-Laws pertaining to the Welfare Committee had been amended.

Resolution No. 4 BASIC SCIENCE

Whereas: The medical profession in Idaho is constantly striving to raise the standards of medical and hospital care for residents of the state, and

Whereas: Many outstanding and important steps in furthering the high principles and concepts of medical care have been advanced in recent years through the diligent and conscientious efforts of members of the medical profession, and

Whereas: Modern medical science is becoming more exacting in the use of new drugs and modern techniques in providing essential care for the sick and injured, and

Whereas: Members of the 31st Session of the State Legislature recognized the importance of aiding in the betterment of the health of the people of Idaho, therefore, be it

Resolved: That a thorough and complete study be made by the Idaho State Medical Association, of Basic Science Laws currently in force in a number of states and that a proposed Basic Science Law be prepared and presented to the 60th annual meeting of the Idaho State Medical Association for approval and endorsement.

Dr. Ross moved that the resolution be approved. Dr. Tall seconded the motion which was unanimously approved.

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Resolution No. 5 INFANT MORTALITY

Whereas: In Idaho in 1950 there were 417 infant deaths, 109 of which were due to immaturity and 126 were reported as being due to birth injuries, asphyxia, and infections of the newborn, and

Whereas: There were 251 stillbirths, and

Whereas: There were 15,666 live births in Idaho, 98 per cent of which were attended by physicians, and

Whereas: Infant death rates and stillbirth rates in the past six years in Idaho have varied widely in the counties of Idaho, and

Whereas: It is thought that this is a matter of interest to all physicians in Idaho; therefore, be it

Resolved: That the Idaho State Medical Society approve the formation of a committee of especially interested physicians to study the problem and if it is necessary, visit various parts of the state to study the first-hand local problems and to make recommendations to hospital administrators and physicians where it is thought improvement might be made.

Dr. McRoberts moved that the Resolution be adopted. Dr. Migel seconded the motion which was unanimously approved.

Resolution No. 6 GROUP HEALTH AND ACCIDENT

Whereas: There has been considerable research toward, and discussion concerning, the adoption of a group health and accident insurance plan for the members of this society; and,

Whereas: It appears that one District Association, being a component part of this organization, has adopted a group accident and health insurance program, which is to the material benefit, advantage, and protection of all of its comprising members, and

Whereas: It appears that such a program, if adopted, upon an association level would be of extreme value and benefit to the individual members of this association by providing non-cancellable health and accident insurance of a type and kind otherwise not available, therefore, be it

Resolved: That the Idaho State Medical Association go on record as being in favor of such a plan of group health and accident insurance for its individual members, and that the officers of the association be authorized to investigate and submit to the individual members a favorable insurance plan for their individual approval.

Dr. Woolley moved that the Resolution be adopted. Dr. McRoberts seconded the motion which was unanimously approved.

Resolution No. 7 DIETETICS MANUAL

Whereas: Interested members of this society co-operating with the Idaho State Dietetics Association have prepared a Dietetic Manual available to hospitals and physicians without cost, and

Whereas: The welfare of the hospitalized patient is benefited by such information, therefore, be it

Resolved: That this society go on record as approving publication of such a manual.

A motion was made by Dr. Ross that the Resolution be adopted. The motion was seconded by Dr. Burton and approved.

Resolution No. 8 ARMED FORCES MEMBERSHIPS

Whereas: With the war in Korea and the present plans for enlargement of the Armed Forces, many doctors will be leaving Idaho for military duty, and

Whereas: The Northern Idaho District Medical Society has voted to give free membership in the local society to its members in the Armed Forces, and

Whereas: The local society cannot determine a policy for the state society in the relationship, therefore, be it

Resolved: That the Idaho State Medical Association extend free memberships in the state society to its members while they are in the Armed Forces.

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Dr. Tall moved that the Resolution be adopted. Dr. Wendell seconded the motion which was unanimously approved.

Resolution No. 9

LABORATORY STANDARDIZATION

Whereas: Medical laboratory determinations generally in the State of Idaho are recognized as being substandard, and

Whereas: Medical laboratory determinations are of prime importance in diagnosis and treatment of a wide variety of diseases, and

Whereas: The necessity of able direct professional medical supervision of technologists engaged in making such determinations has not been recognized by many hospitals, related institutions, and individuals, and

Whereas: The welfare of patients in such hospitals and other institutions and the body of society can best be served by accurate and responsible laboratory determinations, therefore, be it

Resolved: That the Idaho State Society of Pathologists requests that the Idaho State Medical Association appoint a committee representative of medical practice including one pathologist, and that such committee be charged with the following duties: (a) To survey medical laboratory facilities as they now exist in the state. (b) To recommend further steps for the improvement and standardization and professional responsibility for such laboratories.

It is recommended that these duties be performed during the ensuing year, and that report be made at the next annual meeting of the Idaho State Medical Association.

Dr. Woolley moved that the Resolution be approved. Dr. Bonebrake seconded the motion which was unanimously approved.

Resolution No. 10

POST-MORTEM EXAMINATIONS

Whereas: The more frequent performance of post-mortem examination of the bodies of deceased persons is basic to improved medical practice and to the welfare of society, and

Whereas: There is no law of record in the State of Idaho regulating the responsibility for granting permission for such autopsy, and

Whereas: The State of Wisconsin approved on July 9, 1949, such a law in the following sense:

Consent for a licensed physician to conduct a post-mortem examination of the body of a deceased person shall be deemed sufficient when given by whichever one of the following assumes custody of the body for purposes of burial: father, mother, husband, wife, child, guardian, next of kin, or in the absence of any of the foregoing, a friend, a person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of one of them shall be deemed sufficient. Therefore, be it

Resolved: That the Idaho State Society of Pathologists requests the Idaho State Medical Association recommend and urge the passage of such a law in Idaho.

And that the proper committee obtain exact information of the wording of the Wisconsin Law and make it available for the consideration of the next meeting of the Legislature of the State of Idaho.

Dr. Rigby moved that the Resolution be adopted. Dr. Beymer seconded the motion which was unanimously approved.

President Scott called upon Dr. John Z. Bowers, Dean of the University of Utah, Salt Lake City, to discuss inter-state relationship and plans being made to use Kellogg Foundation Funds for post-graduate courses.

Dr. Roy Eastwood, Chairman of the Auditing Committee, reported that the books of the association had been correctly audited by the firm of Elmer Fox, Certified Public Accountant, Boise, and that the audit revealed the financial structure of the association as satisfactory.

Dr. Ross moved that the report be adopted. Dr. Bond seconded the motion which was unanimously approved.

Being no further business, the House of Delegates recessed until 8:30 a.m., Tuesday, June 19.

Third Meeting of the House of Delegates

Tuesday, June 19

Opera House

The House of Delegates was called to order by President Scott and roll call showed a quorum present.

J. O. Cromwell, Superintendent of the State Hospital South, Blackfoot, had requested an opportunity to discuss the new hospitalization and commitment law for the mentally ill with members of the House of Delegates, and at this time President Scott introduced Dr. Cromwell.

A thorough explanation of the new law was given by Dr. Cromwell.

Hoyt B. Woolley, Delegate to the American Medical

Association, gave a verbal report of the recent meeting of the A. M. A. held in Atlantic City.

At this time, newly elected officers were presented to the House and Alfred M. Popma assumed the office of President.

The dates for next year's 60th annual meeting were announced as follows: June 16, 17, 18, 1952, with the House of Delegates to meet for a business session at Sun Valley on June 15.

There being no further business, Dr. Popma announced the House of Delegates adjourned.

Idaho State Medical Association Component Societies

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Montpelier	Grace	Wallace	Kellagg
Bonner-Boundary Counties Society		South Central District Society	
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Sandpoint	Priest River	Twin Falls	Twin Falls
Idaho Falls Society		Southeastern District Society	
President, D. H. Smith	Secretary, H. R. Fishback, Jr.	President, R. B. Hegsted	Secretary, M. M. Graves
Idaho Falls	Idaho Falls	Pocatello	Pocatello
Kootenai County Society		Southwestern District Society	
President, R. T. Henson	Secretary, C. G. Barclay	President, W. B. Rass	Secretary, M. M. Burkhalter
Coeur d'Alene	Coeur d'Alene	Nampa	Baise
North Idaho District Society		Upper Snoke River Valley Society	
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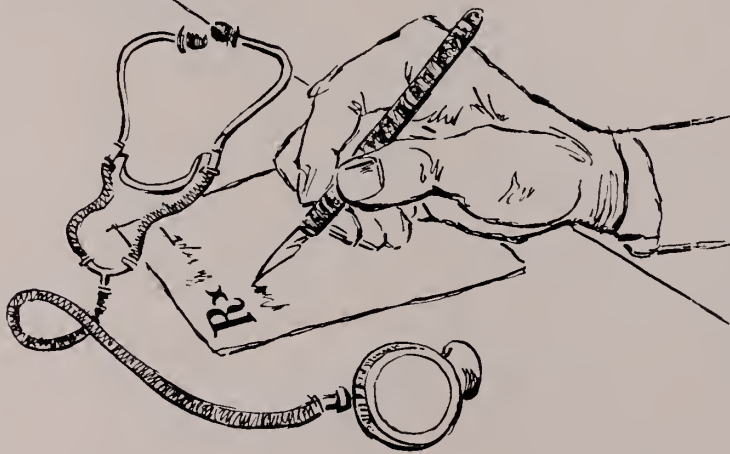
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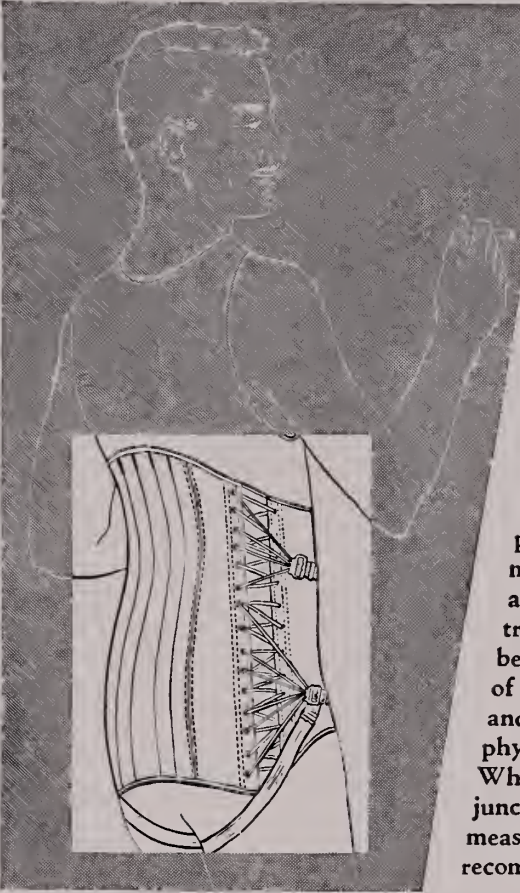
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**Philip Lewin, M.D., F.A.C.S.
 Backache and Sciatic Neuritis,
 Chapter XXXIX, Page 580
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1. Towse, R. C., Berberian, D. A., and Dennis, E. W.: *New York State Jour. Med.*, 50:2035, Sept., 1950.
2. Berberian, D. A., Dennis, E. W., and Pipkin, C. A.: *Am. Jour. Trop. Med.*, 30:613, Sept., 1950.



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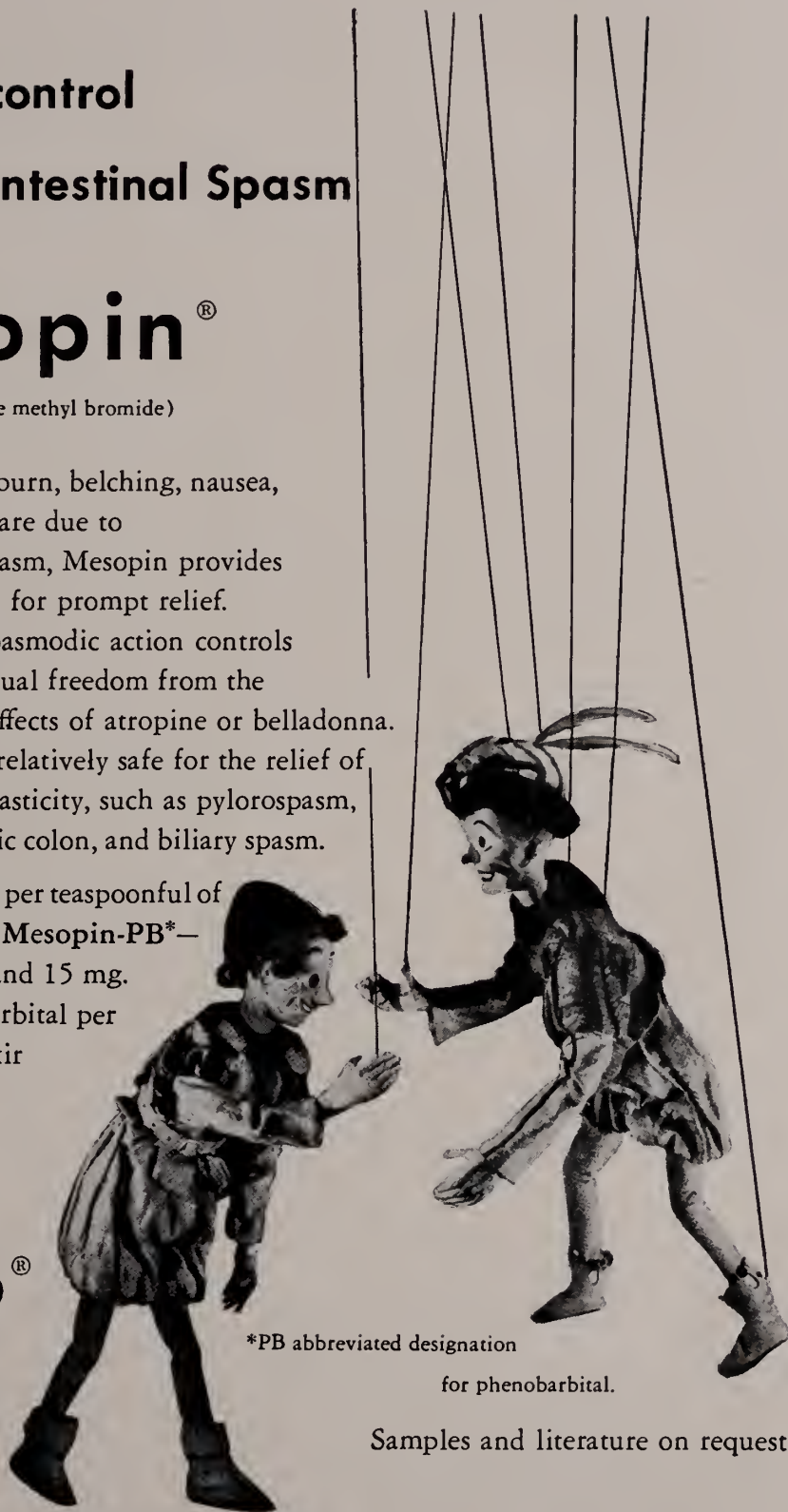
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REFERENCES:

1. Bicknell, F. and Prescott, F.: *The Vitamins in Medicine*, 2nd ed., Heinemann, 1946.
2. Dunnigan, W. M. et al: *Ohio J. Sc.* 44:123, 1944.
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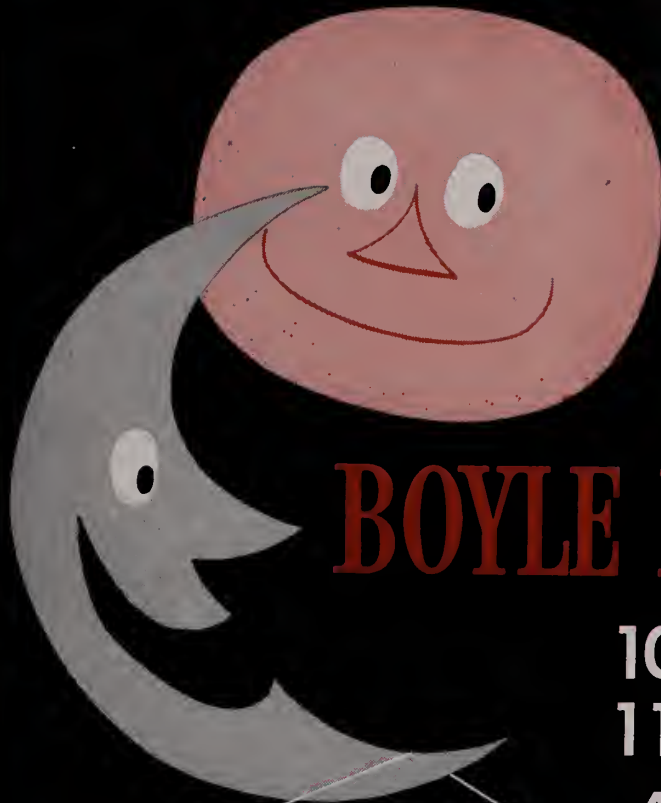
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1. Jeans, P. C.: Feeding of Healthy Infants and Children, J.A.M.A. 142:806 (Mar. 18) 1950.

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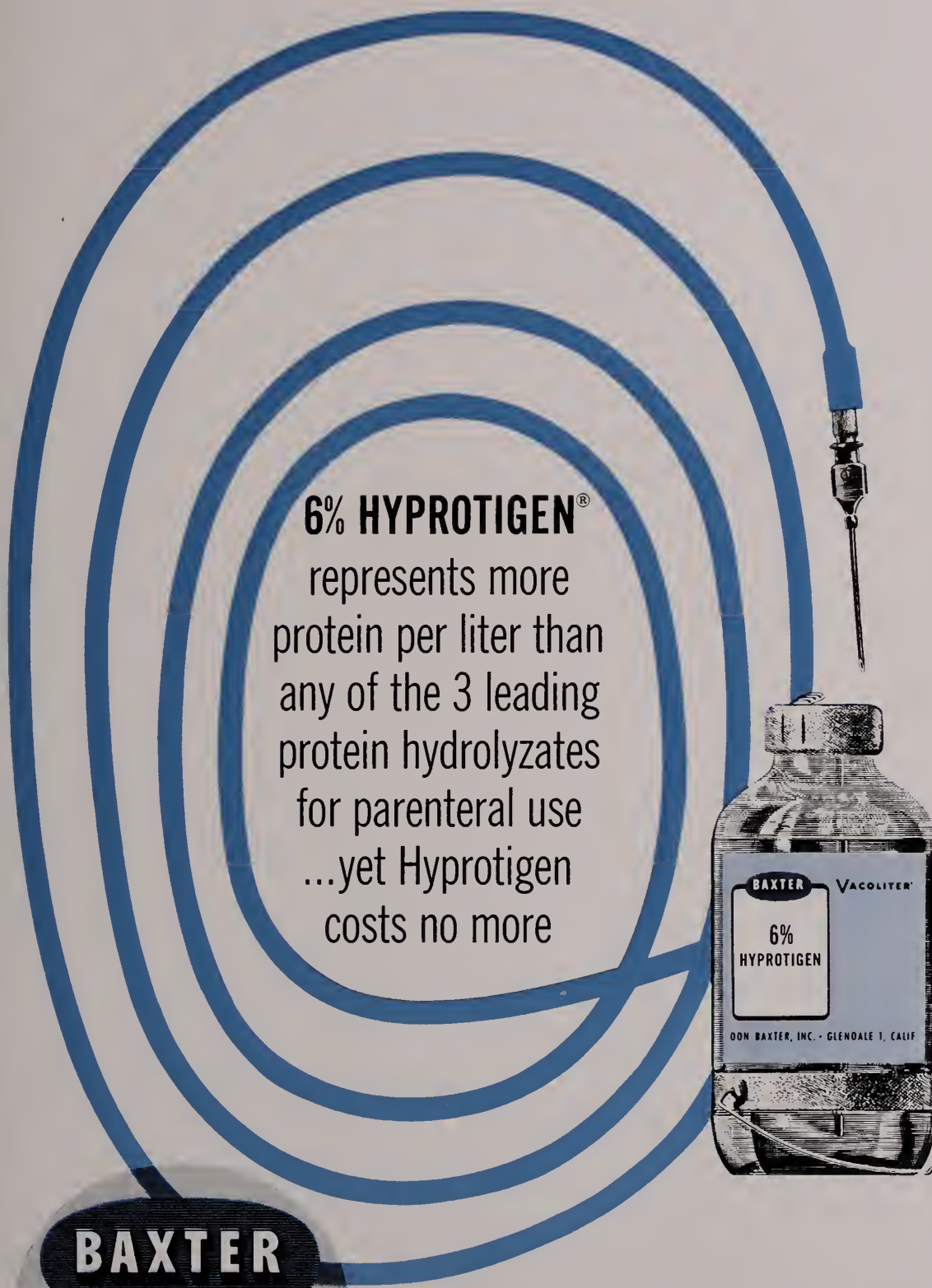
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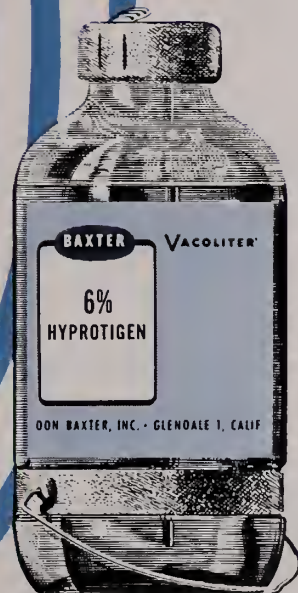
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Vol. 50

SEPTEMBER, 1951

No. 9

Attention, Please!

Influence of Rutin on Diabetic Retinitis—Palmer, et al.

Oregon's 77th Annual Convention—Oregon Section

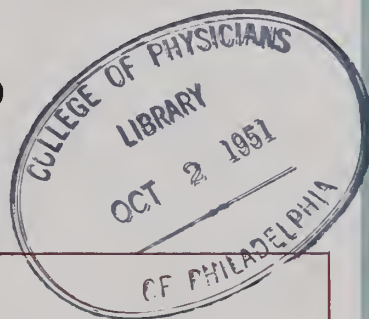
Venous Obstruction in Upper Extremity—Querna

Clinical Medicine

Research Projects—Page 710

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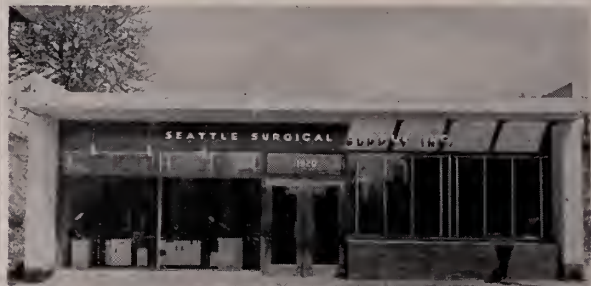
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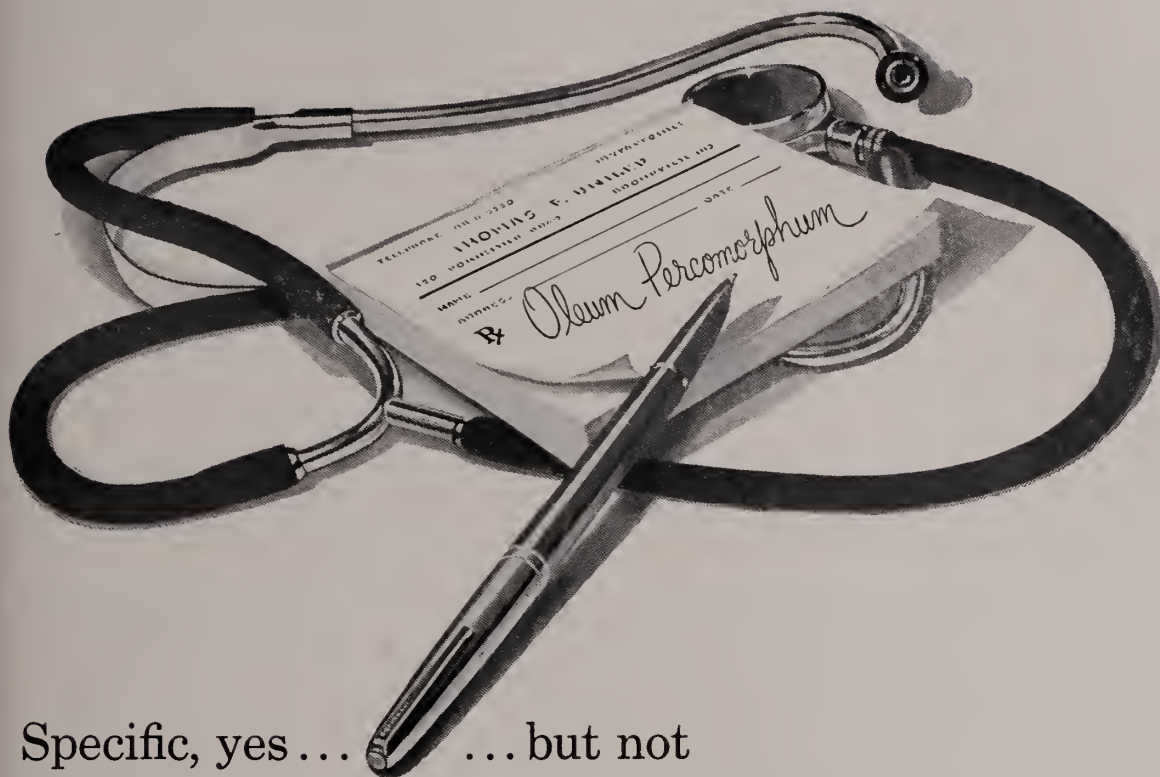
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ANDROMACHI

PHS WORRIES OVER MALARIA IMPORTS. Numerous veterans from Korea have been showing up with malaria. All state health departments have been warned by PHS. (See Washington section this issue.) Former medical officers will recall how quickly malaria would show up when troops left malarious areas and stopped atabrine. Also how promptly another infection or exposure would precipitate an attack. Fortunately, the Northwest does not have anophelens in sufficient numbers to make it a public health measure.

MAYBE THE PSYCHIATRISTS KNOW WHY. Americans are consuming barbiturates at a great rate. Production of the drugs is still on the increase. Suicides and accidental deaths from overdose are up 1,000 per cent in less than 20 years.

ARTHRITIS YARDSTICK. An English investigator, wisely skeptical of claims for various therapies of rheumatoid arthritis, points out a serious error in usual methods of evaluation. He recorded observations on eight cases of rheumatoid arthritis who received no treatment at all. Patients were questioned once an hour for eight hours, then after twelve and twenty-four hours. Remarkable improvements were recorded at times. Pain, range of movement and general feelings were investigated. Variations in changes in these three areas were observed but when changes were recorded, all factors changed in the same direction. Author's conclusion was that serial clinical assessment is worthless as a method of evaluating treatment of arthritis unless careful statistical control is applied. Article is by P. D. Bedford, Oxford, England, and appears in *Annals of the Rheumatic Diseases* for June.

MOVIES AVAILABLE. Write to Committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn St., Chicago 10, Ill., if you want their up-to-date list of "Sources of Motion Pictures on Health." This is a nine-page mimeographed list showing addresses of loan and rental libraries as well as libraries of the various state departments of health. It also includes references to printed lists and catalogs.

Woodrow Wilson once said, "I have always been among those who believed that the greatest freedom of speech was the greatest safety, because if a man is a fool, the best thing to do is to encourage him to advertise the fact by speaking."

Upjohn has announced two new products of considerable interest. One of these, *Neomycin*, is offered as powder for preparation of solutions for topical

application, as ointment containing 5 mg. neomycin sulphate per gram and as ophthalmic ointment in the same strength. Neomycin is prepared from a soil organism, *Streptomyces fradiae*. It is stable at room temperature in aqueous solution for at least five months. This new antibiotic is active against both gram-positive and gram-negative organisms. Parenteral use is not yet recommended because of certain indications of toxicity after prolonged use. Local applications, however, are safe, relatively non-sensitizing and highly effective. Second Upjohn product is *Plazmoid*, a gelatin preparation for prevention and treatment of shock. Gelatin is not metabolized when given intravenously so that its use is confined solely to maintenance of circulating blood plasma volume. In this field it is recommended as a substitute for blood or plasma when the latter are not available.

EXERCISE BETTER THAN SURGERY. Problems of pelvic support and incontinence plus the various bearing down sensations, bladder pressure, vaginal pressure, dragging sensation and kindred complaints may yield to muscle training. E. G. Jones of the University of Southern California so states in July issue of his school's *Medical Bulletin*. Trick is to get the patient to strengthen by exercise the levator muscles through which pass the urethra, vagina and anal canal. Some are helped by an instrument called a perineometer which visibly dials contraction effort. Pretreatment examination includes note of tension along urethra when muscles of mid-vagina are contracted, whether or not bladder elevates, whether bladder floor is below lower border of pubic bone in standing position and whether urethra is directed horizontally or upward. Older single criterion of bulging is largely discarded since a bulging bladder may be made continent and comfortable by exercise of levators.

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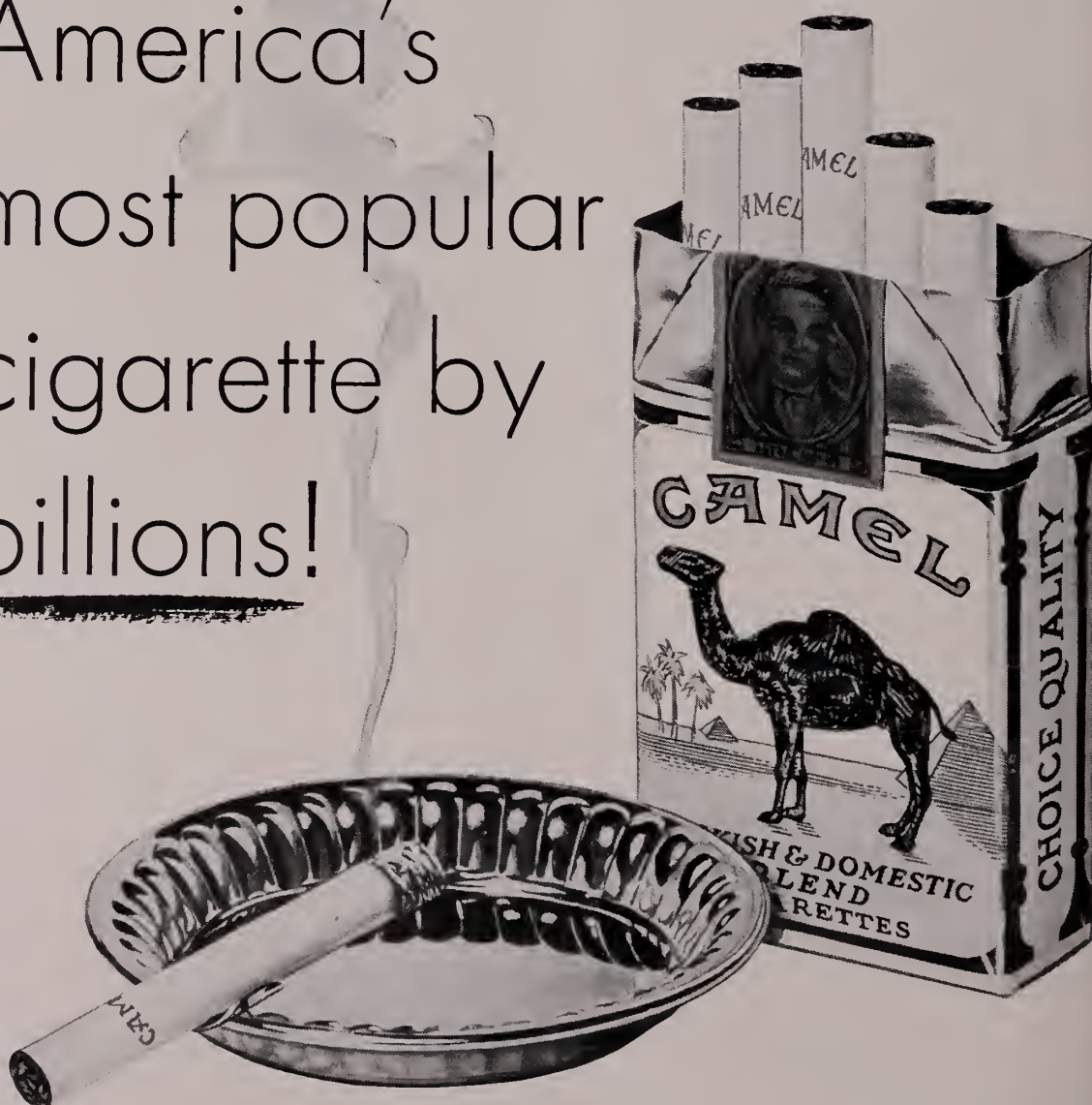
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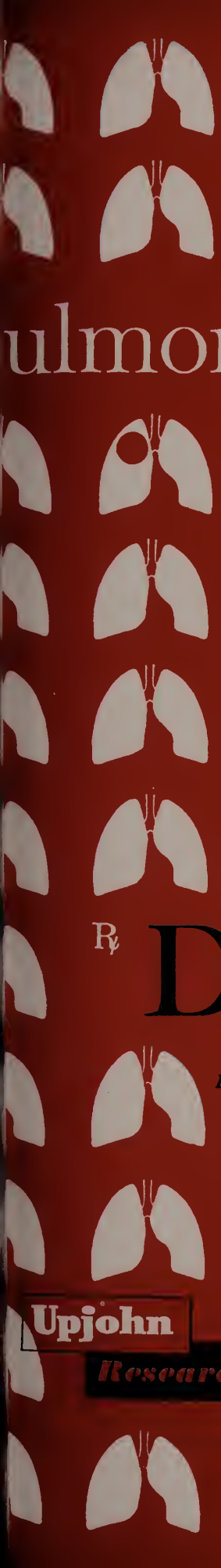
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1. Bauer, Gunnar: Nine Years' Experience with Heparin in Acute Venous Thrombosis. *Angiology*, Vol. 1, No. 2, (Apr.) 1950.

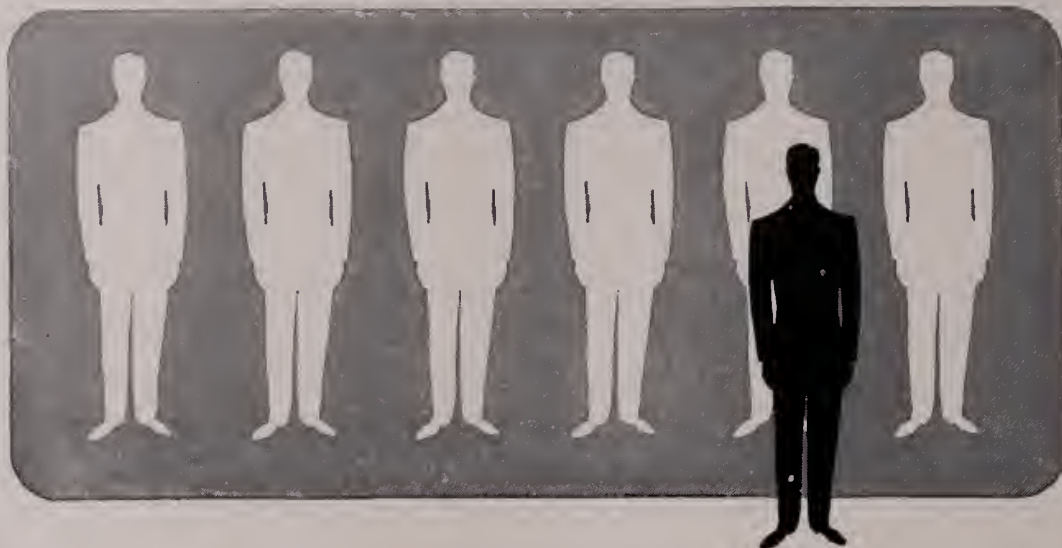
2. Smiles, William J. Long-Acting Heparin Preparation: A Useful Adjunct in Anticoagulant Therapy. *U. S. Armed Forces Med. J.*, Vol. II, No. 1 (Jan.) 1951

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1. Towse, R. C., Berberian, D. A., and Dennis, E. W.: *New York State Jour. Med.*, 50:2035, Sept., 1950.
2. Berberian, D. A., Dennis, E. W., and Pipkin, C. A.: *Am. Jour. Trop. Med.*, 30:613, Sept., 1950.

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*Clein, N. W.: Cow's Milk Allergy in Infants, *Annals of Allergy*, March-April, 1951.

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- 1 Krantz, Kibler and Bell: "The Neutralization of Gastric Acidity with Basic Aluminum Aminoacetate," J. Pharmacol. and Exper. Therap., 82:247 (1944).
- 2 Paul, W. D., and Rhomberg, C.: "Medical Management of Uncomplicated Peptic Ulcer," J. Iowa M. Soc. 35:167-85 (1945).
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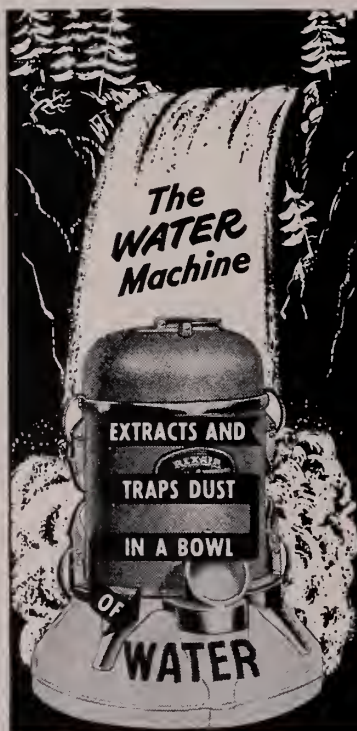
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Vol. 50, No. 9

SEPTEMBER, 1951

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EDITORIALS

Salem Newspaper Stumbles Over Abortion Mess

Peculiar by-product of the Portland abortion scandal comes to light in editorial columns of the July 10 edition of the *Statesman*, a daily newspaper published in Salem. The editorial, under heading of "Ethics and a Higher Code," can hardly be overlooked since it contains so many surprising inaccuracies and grossly misleading statements.

The *Statesman* complains that "The medical profession prefers to take care of its own in its own way, keeping its skeletons discreetly within the family." Implication of this astounding statement is that the medical profession is composed of doctors of medicine and doctors of other schools of what are loosely called the healing arts. This is a foul blow for which the *Statesman* owes profound apology to the Oregon State Medical Society as well as to every honest physician in the Northwest.

Not only should the Salem publication find out just what is meant by the term, *medical profession*, but also it should make some effort to discover what is going on in the world. Writer of the editorial, if half as well informed about medical matters as his glib misquotations of the Hippocratic Oath attempt to show him, should have heard something about the Alameda Plan. He ought to know why it has set the pattern for county medical societies all over the land. If he reads anything other than his own writing he should have learned, by this time, that one of the finest things about the Alameda Plan is that, under direction of its grievance committee physicians are not only willing to testify against erring physicians but have also helped injured persons obtain just settlement out of court.

The myth that "doctors protect their dishonorable colleagues for the sake of the clan—" has long since been exploded and the *Statesman* should know it.

Undiscriminating and unfounded charges of protection of physicians guilty of malpractice would be bad enough. But to accuse the medical profession of harboring those pariahs who pursue their rotten trade because of greed alone, constitutes nothing less than slander. The editorial again strikes below the belt when it asks the question "Were there kick-backs in fee to the doctors who referred patients to their less squeamish comrades?" It is difficult to maintain that equanimity which Osler recommended to all physicians in the face of such colossal insult.

While the *Statesman* was unjustifiably attempting to smear the medical profession, its own hands were not exactly lily-white. As a part of the general public the newspaper and its editor cannot escape a very large share of responsibility for this nasty business. Our civilization has produced a certain demand from the public for abortion. It has been encountered by every physician who ever practiced medicine and it has been steadfastly refused except by a very few individuals, usually those who have failed in normal professional fields. The demand springs from almost total failure of society, including newspapers, to solve certain fundamental problems. If the sanctimonious *Statesman* wishes to make an honest contribution to society, let it roll up its sleeves and tackle the real culprits—the social maladjustments upon which the jackals feed.

Arthritis and Rheumatism Foundation

Arthritis and Rheumatism Foundation is offering research fellowships in the basic sciences related to arthritis. Fellowships will be granted to undergraduates as well as graduates. Undergraduate fellowships will range between \$1,500 and \$3,000 per

annum and the graduate from \$3,000 to \$6,000. Deadline for these applications is November 15, 1951. Application forms may be obtained by writing the Medical Director, Arthritis and Rheumatism Foundation, 535 Fifth Ave., New York 17, N. Y.

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The Nominating Committee

Purpose of a nominating committee should not be misconstrued. Failure to grasp its significance occurs at times, in spite of the fact that the device is so commonly used in democratic organizations. The nominating committee is a useful tool. Its purpose and function should be thoroughly understood.

In some organizations officers are elected by the entire membership and in others by representatives or delegates who themselves are responsible directly to the membership. Regardless of the method of election it is necessary to name certain candidates for each office. This may be done by the body as a whole or by representatives in regular session. The process, of course, is called nomination. It is primarily the duty of the assembly, either of the whole organization or of representatives. If nominations are delegated to a committee, the assembly always retains right of final action. The nominating committee merely presents a report which is acted upon by the assembly before the electing vote is taken. The report may be accepted, modified, amended, supplemented or rejected. Final nominations are not the responsibility of the committee but only of the assembly.

Exactly as in all other committee work, that of the nominating committee is simply intended to save time and effort of the assembly. A few individuals with ample time are always able to give more consideration to a problem than can be allowed in a session of the assembly. In the case of the nominating committee it is quite possible to peruse records, scan lists of names and freely discuss qualifications. Such careful and systematic canvass of membership for officer material could scarcely be employed by the larger group. Thus the nominating committee, as any other committee, merely represents a device by which the assembly may save much time and effort.

It is perfectly right and proper that the nominating committee should occasionally suggest the name of one of its own members as a candidate. This is done at times in spite of the fact that charges of self-promotion are sure to be leveled by the unthinking. If the assembly does not like the suggestion it has not only the clear right but the absolute legal obligation to reject the report of the committee and name a more acceptable candidate. It is that body which always must have the final word.

Invitation from British Columbia

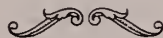
Vancouver General Hospital has extended cordial welcome to physicians of the Northwest states to attend its series of refresher courses. This announcement may be found on Page 658 of this issue. It is suggested that the announcement be clipped and filed for future reference.

These courses are now in their fourth year and interest in them has grown steadily. Attendance from British Columbia as well as Alberta and Washington has been increasing. They are given by practical men and are designed especially for the general practitioner. Full use is made of the facilities and clinical material of the Vancouver General Hospital, an institution of 1200 beds.

Suggestion that physicians from the States attend

these meetings brings into focus a concept which has been growing of late. It is that Western Canada and Northwest United States constitute a region of great mutual interest. Similarity of climate, scenery, industry and population are part of the story. More significant are the great similarities in medical thought and medical practice. We speak the same language, both literally and figuratively.

The friendliness which so readily extends in both directions across the thin line which divides us may well ripen some day into more active relationships. In the meantime, physicians may well develop further their means of communicating with one another and explore the possibilities inherent in their mutuality of interest.



ORIGINAL ARTICLES

The Influence of Rutin Upon Diabetic Retinitis*

LESTER J. PALMER, M.D., NEIL F. FLAHERTY, M.D., JOSEPH H. CRAMPTON, M.D., and
ROGER H. JOHNSON, M.D.

SEATTLE, WASH.

THE high incidence of retinitis in diabetes mellitus is generally appreciated. When it progresses to blindness, retinitis presents one of the most tragic complications of diabetes. Many attempts to increase present knowledge of the mechanism of this vascular damage have been initiated to find a treatment which will effectively prevent or alter the disease.

Beaser et al,¹ were among the first to report that increased capillary fragility was present to a greater extent in diabetics than in nondiabetics, that it was more frequent in the fifth and sixth decades, and that 100 per cent of the diabetic patients with associated hypertension showed increased capillary fragility. In their study of capillary fragility, Rodriguez and Root² concluded that the incidence of increased capillary fragility was more closely related to duration of the diabetes than to age of the patient.

Diabetic retinitis may be influenced by many other factors. Patients treated with a high protein diet by Schneider et al.,³ showed marked improvement in retinal hemorrhages with elevation of the serum albumin to normal. Wilder⁴ states that retinal hemorrhage may be precipitated by insulin hypoglycemic reactions and Lawrence⁵ feels that careful diabetic control may inhibit progression of retinitis. Leopold⁶ observed 100 cases treated for ten years with standard medication and concluded that deep retinal hemorrhages and exudates increased with duration of the diabetes but may be slightly decreased following strict diabetic control. When hypertension is present, diabetic retinitis tends to progress more rapidly. Barnes⁷ also pointed out

that long duration of diabetes and poor diabetic control, as for example recurrent ketosis, are factors that predispose to development of retinitis.

Although extensive retinitis at any age is serious, greatest interest in diabetic retinopathy centers in the juvenile group (patients with the onset of diabetes at 15 years of age or under). White and Waskow⁸ found retinal hemorrhages in 75 per cent of 220 juvenile diabetics who had had the disease 20 years or more. Dolger⁹ followed 200 younger diabetics and concluded that retinitis was the prominent vascular lesion which often preceded albuminuria and hypertension.

Retinal hemorrhage is usually associated with increased capillary fragility or increased cutaneous lymphatic flow.¹⁰ Wagener reported that Foxworthy had found that the first petechiae appeared in 4.9 minutes in 85 normal patients. After ten minutes they averaged only 14 petechiae in a circle the size of a quarter. These were compared with 44 diabetics with retinopathy who showed an average appearance time of 1.5 minutes and 101 petechiae in a comparable area.¹¹ Foxworthy noticed no improvement in retinopathy in her patients treated with hesperidin although skin capillary fragility improved in many. It is by no means certain that increased fragility of skin capillaries is accompanied by corresponding dysfunction of retinal capillaries but much of the work done certainly points to that conclusion.

Various drugs have been used in an attempt to reduce capillary fragility in diabetes and to check progression of retinal hemorrhage and exudate formation. Rutin has been investigated in regard to its action in diabetic retinopathy. Rutin is found in 38 species of plants and flowers. This drug was first taken from tobacco plants but at present is isolated from the early blossoming leaves and flowers of the buckwheat plant. It is prepared

*From the Mason Clinic and the Virginia Mason Hospital, Seattle, Wash.

1. Beaser, S. B., Rudy, A., and Seligman, A. M.: Capillary Fragility in Relation to Diabetes Mellitus, Hypertension and Age, *Arch. Int. Med.* 73:18-22, Jan., 1944.

2. Rodriguez, R., and Root, H. F.: Capillary Fragility and Diabetic Retinitis, *New England J. Med.*, 238:391-399, March 18, 1948.

3. Schneider, R., Lewis, L. A. and McCullagh, E. P.: Plasma Proteins; Alteration in Diabetic Retinitis, *Am. J. M. Sc.* 212:462-465, Oct., 1946.

4. Wilder, R. M.: Clinical Diabetes Mellitus and Hyperinsulinism, Philadelphia, W. B. Saunders Co., 1940, p. 275.

5. Lawrence, R. D., and Oakley, W.: Diabetic Retinitis, *Brit. M. J.*, 2:312, Sept. 4, 1943.

6. Leopold, I. H.: Diabetes Mellitus as Observed in 100 Cases for 10 or More Years, Ocular Findings, *Am. J. M. Sc.*, 209:16-23, Jan., 1945.

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8. White, P., and Waskow, E.: Arteriosclerosis in Childhood Diabetes, *Proc. Am. Diabetes A.* 8:141, 1948.

9. Dolger, H.: Clinical Evolution of Vascular Damage in Diabetes Mellitus, *Bull. New York Acad. Med.*, 22:482-483, Sept., 1946.

10. Shanno, R. L., Griffith, J. Q., Jr., and LaMotte, W. O., Jr.: Capillary Fragility and Capillary Permeability in Relation to Retinal Hemorrhage, *Am. J. Ophth.*, 30:1556-1563, Dec., 1947.

11. Wagener, H. P.: Retinopathy in Diabetes Mellitus, *Proc. Am. Diabetes A.*, 5:201-216, 1945.

as a tasteless yellow powder.¹² Wilson et al.,¹³ reported that rutin is nontoxic in albino rats and rabbits, even when given in excessive doses. In clinical use, daily doses of 60 to 180 mg. have been used and no toxic effects have been reported with the purified drug.

Previous appraisals of the efficacy of rutin are not enthusiastic but judgment is reserved regarding its value. Levitt¹⁴ concluded that improvement seen in the retina was no more than could be expected without rutin when good diabetic control is maintained. Rodriguez and Root² reporting on 20 cases found no improvement in the visual fields or retinal picture, even though increased skin capillary fragility could be brought to normal with sufficient doses of rutin. However, Barnes⁷ found little improvement in either capillary fragility or diabetic retinopathy in his 32 cases. Wilder¹⁵ has stated his clinical impression that the progression of retinitis has been delayed in some cases. Donegan¹⁶ was more optimistic and Barnes reported White's clinical impression that the progress of retinitis in juvenile diabetics has been less rapid in those who have used rutin.⁷

Using either rutin or hesperidin, Beardwood et al.,¹⁷ reported that 20 out of 80 cases showed definite improvement in ophthalmologic examination, while in 36 cases given a placebo, only four showed improvement.

Our patients were given no supplementary vitamin C since it was not considered wise to introduce another drug while trying to evaluate rutin. In addition, Sebesta et al., concluded that no relation existed between blood ascorbic acid content and capillary fragility.¹⁸

First procedure was a careful eye examination in which hemorrhages and exudates were counted by one of us (RHJ). Then, all patients were given 60 mg. of rutin† four times a day. While on this drug they received two or more periodic eye examinations. In our series of 54 patients who were started on rutin, 36 were acceptable because of ade-

quate follow-up retinal examinations. Except that every effort was made to maintain good control of the diabetes and to insure adequate regular follow-up, our series of patients was unselected. The criterion for improvement was a decrease in number of previously counted retinal hemorrhages without an increase in exudates. The period of observation while on rutin varied from 7 to 34 months with an average of 15 months per patient. Our results (Table I) reveal that 11 were unchanged, 17 showed progression of retinitis and 8 showed some improvement. This is compared with a series of 66 cases followed by Wagener.¹⁹ His cases of diabetic retinitis had two or more examinations over successive years. Progressive retinal disease was noted in 37 cases, no change occurred in 25 and improvement was observed in four. The percentage of the total series is shown in Table I.

TABLE I
With Rutin—1950 Without Rutin—1934
Wagener

	Number of Cases	Per Cent of Series	Number of Cases	Per Cent of Series
Improved	8	22.2	4	6
Unchanged	11	30.6	25	38
Worse	17	47.2	37	56

From this data, one might presume that rutin had prevented formation of new hemorrhages. However, Wagener's report was published in 1934, before the introduction of protamine zinc insulin and when high fat diets were advocated. Our patients received either protamine zinc insulin alone or in combination with crystalline insulin. Their diets consisted of a fairly liberal protein allowance and carbohydrate to fat ratio of 2:1. Therefore, the two sets of data are not strictly comparable. This comparison is presented mainly to show that there may be some retardation of the progression of diabetic retinitis due purely to good control.

A summary of our cases in the juvenile group appears in Table II.

In these 13 patients who had had proven diabetes from 13 to 30 years, the following results were obtained: While on rutin therapy, two became better, eight were worse, and three remained unchanged. Although most patients who had had diabetes the longest were unimproved or worse, there were two patients who apparently did respond to rutin regardless of the duration of their diabetes.

Donegan¹⁶ believed it significant that no loss of vision or increase in retinopathy occurred during a period of 10 to 12 months' treatment with rutin in his series. In our series, one patient had retinitis which extended to retinitis proliferans and complete

†Material for this study supplied by E. R. Squibb and Sons and Abbott Laboratories.

12. Couch, J. F., Naghski, J., and Krewson, C. F.: Buckwheat as Source of Rutin, *Science*, 103:197-198, Feb. 15, 1946.

13. Wilson, R. H., Mortarotti, T. G., and Dostader, E. K.: Toxicity Studies on Rutin, *Proc. Soc. Exper. Biol. & Med.*, 64:324-327, March, 1947.

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16. Donegan, J. M., and Thomas, W. A.: Capillary Fragility and Cutaneous Lymphatic Flow in Relation to Systemic and Retinal Vascular Manifestations: Rutin Therapy, *Am. J. Ophth.*, 31:671-678, June, 1948.

17. Beardwood, J. T., Jr., Roberts, E., and Trueman, R.: Observations on the Effect of Rutin and Hesperidin in Diabetic Retinitis, *Proc. Am. Diabetes A.*, 8:243, 1948.

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19. Wagener, H. P., Dry, T. J., and Wilder, R. M.: Retinitis in Diabetes, *New England J. Med.*, 211:1131-1137, Dec. 20, 1934.

TABLE II
Juvenile Group With Retinitis

Case Number	Age	Sex	Duration of Diabetes Years	Blood Pressure	Months Rx	Improved	Unchanged	Worse
1	23	F	13	120/80	10			+
2	23	F	16	140/95	25		+	
3	21	F	16	130/90	9		+	
4	27	F	17	145/100	32			+
*5	28	F	18	195/120	16			+
6	29	F	19	135/85	16	+		
7	26	F	20	140/100	10			+
8	33	M	20	125/85	18		+	
9	31	F	21	140/90	14			+
10	27	M	22	140/86	26			+
11	35	F	25	125/70	24	+		
12	29	F	26	130/80	12			+
13	44	M	30	130/75	9			+
TOTAL						2	3	8

*Deceased—Intercapillary Glomerulosclerosis.

blindness while on rutin therapy, and another had rapid progression of retinopathy as follows:

A well-controlled, 23-year-old white female, whose blood pressure was normal, became progressively worse with a rapid increase in retinal hemorrhages and formation of many new white cotton-wool exudates. Because of this, rutin was stopped after four months and we observed that the cotton-wool exudates and also many hemorrhages disappeared. However, in the following months, while not taking rutin, her retinitis again showed marked progression but the cotton-wool exudates did not reappear. Hemorrhage formation was not altered by resuming rutin therapy.

It was thought that the cotton-wool exudates may have been a sign of toxicity to the drug rather than strictly diabetic in origin. Cotton-wool patches are probably a toxemic manifestation in diabetic patients who have no demonstrable hypertensive vascular disease.

DISCUSSION

Our series is probably slightly more optimistic than most previous appraisals of rutin therapy for diabetic retinitis. However, it should be noted that

the juveniles who had the best results while taking rutin were well controlled and had no hypertension or albuminuria. This finding correlates with that of Barnes.²⁰ On the other hand, two patients in this series developed renal failure due to intercapillary glomerulosclerosis (Kimmelsteil-Wilson syndrome). Wagener²¹ believes that the retinitis of Kimmelsteil-Wilson syndrome is a diabetic rather than a hypertensive phenomenon. One woman in our juvenile group with this syndrome showed marked progression of retinitis prior to her demise and a 42-year-old woman in the same category became blind from retinitis proliferans before death.

We would like to emphasize, along with Hollenhorst and Wagener²¹ that retinal lesions of all types are subject to remission. When one considers all the factors that may influence retinopathy, it is difficult to state that rutin definitely decreased hemorrhage formation. Our findings may indicate, however, that rutin should be observed for a longer period of time to justly evaluate it. We are convinced that further investigation of the causes of diabetic retinitis and of the pharmacology of rutin may lead to earlier indications for prescribing this drug.

SUMMARY

1. Thirty-six cases of diabetic retinitis were treated with 60 mg. of rutin four times a day for an average of fifteen months.
2. The retinal picture in eleven patients was unchanged, eight showed improvement and seventeen were worse.
3. Improvement was not much greater than could be expected under good diabetic control with diet and protamine zinc insulin alone. However, our results were sufficiently encouraging to warrant further investigation of rutin.
4. A question of progression of retinitis as a consequence of rutin therapy has been raised.

20. Barnes, R. H.: Personal communication.

21. Hollenhorst, R. W., and Wagener, H. P.: The Effect of Rutin in the Control of Bleeding into the Retina, *Am. J. M. Sc.*, 217:223-231, Feb., 1949.

Venous Obstruction in the Upper Extremity*

MILBURN H. QUERNA, M.D.
SPOKANE, WASH.

Venous obstruction occurs infrequently in the upper, as compared with the lower extremity. It may be of more frequent occurrence than one is led to believe from reports in the literature. The disease is almost never fatal, its course is protracted and often not influenced by treatment, so perhaps this may discourage discussion.

*Read at Twelfth Annual Meeting Spokane Surgical Society, Spokane, Wash., April 8, 1950.

The syndrome was described by Paget in 1875 and Von Schroetter in 1884. Since then numerous authors have described similar cases. Mr. Hughes of London, in 1949, was able to find 320 cases in the literature which form the basis of an excellent collective review.

This condition has a varied terminology, due to the fact that its etiology and pathology are uncertain. It has been called venous thrombosis, traumatic

thrombosis, primary thrombosis, effort syndrome, intermittent venous claudication, traumatic venospasm, Paget-Schroetter's syndrome.

Clinical features make the disease easily recognized. It may occur at any age, is most frequent during the active years, most often in active males and most frequently in the right arm. The onset is heralded by swelling and pain in most cases and may be abrupt or gradual. Often these occur first in the shoulder, then spread down the arm and upward over the pectoral region.

Discoloration, most often a cyanotic hue, occasionally pink or red is noted early. Venous distention is an early prominent finding in all cases. Paresthesias are noted in some cases. Some loss of active movements may be noted. Palpation may reveal a tender cordlike structure in the axilla, presumably a thrombosed axillary vein.

In two of the cases to be presented today a tender structure was noted above the clavicle which was interpreted as perivenous infiltration about the subclavian. In these cases a tender swelling was also noted behind the sternomastoid, presumably the jugular vein. Increased venous pressure is obvious, engorged veins are easily seen and the veins collapse slowly on elevation of the arm.

Venography, while it is not necessary for diagnosis and does not influence treatment, may be of some interest. Roentgenograms are exposed during the injection of diodrast usually into the cubital vein. The point of obstruction and its extent are usually not conclusively demonstrated but a fairly constant feature is the extensive collateral circulation. Infrared photography simply gives a good picture of the clinical findings. Constitutional disturbances are usually mild and transient.

The diagnosis rarely presents difficulty. One must differentiate this type of venous obstruction from that known to occur, due to pressure from abscess, tumor, aneurysm, cervical ribs or as a part of a general disease.

It is by no means certain that the cause of the obstruction is a thrombus, as is the case in the lower extremity. Surgical exploration has rarely demonstrated a thrombus and the clinical course would often seem to make this unlikely. A perivenous infection with resulting vasospasm might be an etiological factor but lack of constitutional reaction makes it rather doubtful.

Trauma is considered most often to be the inciting factor. This may be mild or severe and most cases give such a history. The effort consists of lifting a heavy weight, working with the arm overhead, forcible abduction or external rotation of the arm or a blow on the shoulder or upper chest. In a few cases no history of antecedent trauma is obtained.

A few facts as to the anatomy are worth recalling. These have been used to explain various forces which might injure the vein. The axillary vein passes below the coracoid process and behind the pectoralis minor, and with the arm in hyperabduction, it might be injured here. The vein passes beneath the clavicle, where it is crossed by the costocoracoid ligament and subclavius muscle, and this has been viewed as a point of possible injury. It has been proposed that the vein could be compressed and injured between the clavicle and first rib. It has been suggested that the vein might be compressed between the scalenus anticus and the clavicle. In some individuals the phrenic nerve, instead of following a course posterior to the subclavian vein, lies anterior to it, a so-called preavenous nerve. It is conceivable that this, under certain conditions, could exert pressure and injure the vein.

It is not possible to assign a definite etiology. Surgical exploration of this area is not simple and, when undertaken in this condition, has not been revealing.

Treatment for the most part has been conservative—bed rest, elevation of the arm and heat. Anticoagulants have been tried in a few cases. Paravertebral sympathetic block has been advocated; it may influence the development of collateral circulation. Surgeons have approached this lesion with uncertainty. Exploration has rarely demonstrated a thrombus to remove. Various types of pathology have been described. It is uncertain what role these played in the syndrome. Scalenotomy, excision of a venous segment, periarterial sympathectomy are other procedures which have been tried.

The prognosis is good as to survival, embolism does not occur remarkably enough. Edema of the arm subsides, regardless of what is done. It frequently recurs when the circulation is called upon beyond the capacity of the collaterals. This may result in a prolonged partial disability to a working man and is of medicolegal significance.

CASE REPORTS

Case 1. C. H., age 64, carpenter, seen through the kindness of Dr. R. Hanford in January, 1949. He complained of pain and swelling in the left side of neck, left upper chest and left arm. The symptoms had appeared over a period of three days. The pain was aggravated by coughing or swallowing. There was no history of trauma; he had not worked for a month.

Temperature was 101°. Pulse 84. B.P. 132/68. WBC 9000. There was edema of the left arm, shoulder, pectoral region and above the clavicle. The subclavia and jugular veins were palpable, firm and tender above the clavicle. The axillary vein felt like a firm cord. There was obvious increased venous pressure and collateral circulation.

Swelling disappeared in six weeks and he was able to do ordinary tasks. Has not returned to heavy work.

Case 2. G. C., age 14. In August, 1946, while working at a lumber mill, a cant hook which he held was thrown by a log so that it forcibly abducted his right arm. He had immediate pain in the axilla, radiating

upward and down to the elbow. A discolored swelling appeared in the axilla and beneath the pectoral muscle. The hand, forearm and upper arm became swollen and remained so for two weeks.

He was first seen in October in my office because the swelling had recurred along with a heavy, tired feeling in the arm. There had been no further trauma. On examination, there was noted increased venous pressure in the arm and increased collateral venous channels. The axillary vein was palpable and tender. After five days of rest and elevation, the symptoms and signs disappeared. They recurred three weeks later after exertion and again promptly subsided.

Case 3. R. S., age 24, a farmer, seen through the kindness of Dr. A. Sallquist of this city. On October 3, 1950, he had dug a number of post holes and then sighted in a deer rifle. His right arm became swollen and painful the next day. The pain was dull, originated in the shoulder and radiated down the arm. Abduction of the arm increased the pain. The arm

had a mottled cyanotic hue and was swollen. The arm perspired more freely than the normal. There was tenderness over the axillary vein, signs of increased venous pressure, and prominent collateral venous circulation. Edema gradually subsided and he has returned to most of his former activities.

Case 4. Mrs. H., age 51, awakened on February 14, 1950, with pain in the right shoulder and arm. There were no constitutional disturbances. There was noted a palpable tender cord in the axilla and a tender swelling in the neck was interpreted as thrombosed subclavian and jugular veins. Recovery occurred after ten days of bed rest with elevation of the arm.

Case 5. C. I., age 29, salesman, seen April 7, 1950. The previous day he had dug post holes. The following day he complained of pain and swelling in the right arm. The pain started in the shoulder. Examination showed swelling of the arm, forearm and hand. There was increased venous pressure. A tender cord was palpated in the axilla. He was treated conservatively.

Status of Surgical Treatment of Hypertension

GILMAN E. SANFORD, M.D.
SPOKANE, WASH.

PURPOSE of this publication is to present an evaluation of the present status of surgical treatment of hypertension and a rational approach to selection of patients for surgical treatment. It also presents a basis for selection of the operative procedure most suitable to the individual patient.

The modern concept of essential hypertension is that it is a condition resulting in hyper-reactivity of smooth muscle causing an elevation of blood pressure by increased peripheral resistance. It is associated with or followed by vascular disease. The sequence of events is probably initiated by a combination of neurogenic and humoral factors. Evidence pointing to a neurogenic component in the etiology of hypertension prompted the first attempts at treatment by sympathectomy. It is also known that following sympathectomy there is a modification of reflex control of blood pressure. Wilkins^{1,2} has demonstrated that following denervation of the splanchnic bed reflex elevation of pressure due to vasoconstriction is abolished or modified. Actual lowering for one to five years has been demonstrated.

It is presumed that denervation of the splanchnic bed abolishes reflex epinephrin secretion. It is also presumed that there is stabilization of blood flow through the viscera with decrease in the periods of visceral vasoconstriction. This should decrease the possibility of pressor substances being elaborated by viscera in response to periods of ischemia.³

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EVALUATION OF TREATMENT

Efficacy of treatment of hypertension must be judged by its ability to produce (1) prolongation of life, (2) relief of symptoms, and (3) increased ability to live a useful life. Determination of these results is difficult for there are too few series of cases with adequate follow-up. There are also too few control series followed without treatment to ascertain the natural course of hypertension. Wil-

TABLE 1
COMPARISON OF MORTALITY OF NON-TREATED, MEDICALLY TREATED AND SURGICALLY TREATED HYPERTENSIVE PATIENTS

Author	MEDICALLY TREATED CASES		
	No. of Cases	Time Followed	Mortality Per Cent
Janeway (1915)	244	5-10 yrs.	81
Blackford, Bower & Baker (1930)	202	5-11 yrs.	50
Keith, Wagener & Barker (1939)	219	5-9 yrs.	91
Rasmussen & Boe (1945)	100	6-yr. av.	52
Bechgaard (1946)	1038	4-11 yrs.	28
Palmer, Loofbourow and Doering (1948)	430	8-yr. av.	61
TOTAL	2233	Average	50

Author	SURGICALLY TREATED CASES		
	No. of Cases	Time Followed	Mortality Per Cent
Peet & Isberg (1946)	437	5-12 yrs.	42.5
Smithwick (1948)	326	5-10 yrs.	29
Fishberg (1948)	119	1-6 yrs.	18.4
Ray (1949)	300	1-6 yrs.	11.7
Grimson (1949)	113	1-8½ yrs.	14.2
Hinton (1949)	437	1-5 yrs.	13
Evans (1949)	173	½-3 yrs.	7
Peet & Smithwick.....	763	Average	36.9

NON-TREATED CASES

Author	No. of Cases	Time Followed	Mortality Per Cent
Griegel	117	8-10 years	54.7

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kins⁴ has stated approximately 25 per cent of cases will stabilize and the patient be relatively asymptomatic without treatment. Undoubtedly, lack of progression has at times been attributed to some form of therapy when it was actually the natural course of the disease.

It has been shown that surgical treatment will relieve subjective symptoms in 80 per cent to 95 per cent of cases.^{5,8} Table 1 gives a comparison of total mortality in untreated, medically treated and surgically treated cases. The cases of Peet and Smithwick constitute the only series of surgically treated patients that have been followed long enough to be truly significant. Their series show a significant reduction of total mortality. Table 2 summarizes the reduction of blood pressure and improvement in retinal, cardiac and renal changes reported by various authors following surgical treatment.

TABLE 2
REDUCTION OF BLOOD PRESSURE & IMPROVEMENT IN CARDIAC, RETINAL AND RENAL STATUS IN HYPERTENSION FOLLOWING SURGICAL TREATMENT

Author	Reduction in Blood Pressure	Improvement in Abnormal Electrocardiogram	Reduction in Heart Size	Improvement in Retinal Changes	Decrease Nocturia and Improved Renal Function
Peet	46.7%	55.4%	44%	82%	Nocturia 45%
Smithwick	60%	60%			
Ray	50%	61%			
Hinton*	diastolic below 100 24% & 54%				
Evans†	61%	45%	90%	62%	Nocturia 75% Renal function 58%
Grimson	65%				

*24% with sympathectomy D8 to L2.

54% with sympathectomy D4 to L3.

†Computed from Evans' figures.

Immediate mortality and morbidity must also be considered in evaluating surgical treatment. Operative mortality averages less than 2 per cent.^{5,6,18,21,24-27} Hospital stay will average one month. The average patient should be able to resume useful activity within three to five months after operation.

Available evidence thus indicates that surgical treatment results in prolongation of life, relief of symptoms and increased ability to lead a useful life. It should be emphasized that surgery is not a cure for hypertension. A small minority will obtain what appears to be a cure for hypertension, the majority of properly selected cases receive benefit and some are not benefited at all. Consequently, patients must be selected for surgical treatment by very careful study.

SELECTION OF PATIENTS FOR SURGICAL TREATMENT

In general, it may be stated that patients with hypertension are candidates for surgical treatment if they meet the following requirements:

1. They are true cases of essential hypertension. Known causes of hypertension²⁸ must be ruled out. However, patients with unilateral kidney disease may show better results if sympathectomy is performed in addition to nephrectomy, as only 10 per

7. Penick, R. M.: Evaluation of Treatment of Essential Hypertension by Sympathectomy. *Ann. Surg.*, 129: 872-877, June, 1949.

8. Rogers, W. F. and Palmer, R. S.: Essential Hypertension: Diagnosis and Comparison of Medical and Surgical Treatment. *Am. Pract.*, 1:459-464, May, 1947.

9. Janeway, T. C.: Clinical Study of Hypertensive Cardiovascular Disease. *Arch. Int. Med.*, 12:755-798, Dec., 1913.

10. Blackford, J. M., Bowers, J. M. and Baker, J. W.: Follow-up Study of Hypertension. *J. A. M. A.*, 94:328-333, Feb. 1, 1930.

11. Keith, N. M., Wagener, H. P. and Barker, N. W.: Some Different Types of Essential Hypertension, Their Course and Prognosis. *Am. J. M. Sc.*, 197:332-343, March, 1939.

12. Rasmussen, H. and Boe, J.: Prognosis of Essential Hypertension, with Remarks Respecting Indications for Operative Treatment. *Acta. Med. Scandinav.*, 120:12-31, 1945.

13. Bechgaard, P.: Arterial Hypertension; Follow-up Study of One Thousand Hypertensives. *Acta. Med. Scandinav.*, supp., 172:3-358, 1946.

14. Palmer, R. S., Loofbourrow, D. and Doering, C. R.: Prognosis on Essential Hypertension: Eight-year Follow-up Study of 430 Patients on Conventional Medical Treatment. *New Eng. J. Med.*, 239:990-994, Dec. 23, 1948.

15. Peet, M. M. and Isberg, E. M.: Surgical Treatment of Essential Hypertension. *J. A. M. A.*, 130:467-473, Feb. 23, 1946.

16. Smithwick, R. H.: Continued Hypertension; Prognosis for Surgically Treated Patients. *Brit. M. J.*, 2:237-243, July 31, 1948.

17. Fishberg, A. M.: Sympathectomy for Essential Hypertension. *J. A. M. A.*, 137:670-675, June 19, 1948.

18. Ray, B. S.: Surgical Treatment of Hypertensive Vascular Disease. *M. Clin. North Amer.*, 33:735-749, May, 1949.

19. Grimson, K. S., Orgain, E. S., Anderson, B., Broome, R. A., Jr. and Longino, F. H.: Results of Treatment of Patients with Hypertension by Total Thoracic and Partial to Total Lumbar Sympathectomy, Splanchnicectomy and Celiac Ganglionectomy. *Ann. Surg.*, 129:850-871, June, 1949.

20. Hinton, J. W.: End Results of Thoracolumbar Sympathectomy for Advanced Essential Hypertension. *Calif. Med.*, 70:282-287, April, 1949.

21. Evans, J. A.: Selection of Patients for Sympathectomy. *S. Clin. North Amer.*, 30:813-827, June, 1950.

22. Griep, A. H., Berry, G. R. and Hall, W. C.: Prognosis in Untreated Arterial Hypertension: Report on One Hundred Seventeen Patients under Fifty-three Years of Age, Followed Eight to Ten Years. *Am. J. Med.*, 6:664, 1949.

23. Isberg, E. M. and Peet, M. M.: Influence of Suprardiaphragmatic Splanchnicectomy on the Heart in Hypertension. *Am. Heart J.*, 35:567-583, 1948.

24. Peet, M. M.: Hypertension and Its Surgical Treatment by Bilateral Suprardiaphragmatic Splanchnicectomy. *Am. J. Surg.*, 75:48-68, Jan., 1948, April, 1948.

25. Smithwick, R. H.: Surgical Treatment of Hypertension. *Am. J. Med.*, 4:744-759, May, 1948.

26. deTakats, G., Julian, O. C. and Fowler, E. F.: Surgical Treatment of Essential Hypertension: Case Selection and Technique as Influencing Results. *Surgery*, 24:469-479, Sept., 1948.

4. Wilkins, R. W.: Essential Hypertension: Present Status of the Problem. *M. Clin. North America*, 30:1079-1083, Sept., 1946.

5. Evans, J. A. and Bartels, C. D.: Results of High Dorsolumbar Sympathectomy for Hypertension. *Ann. Int. Med.*, 30:307-329, Feb., 1949.

6. Hinton, J. W. and Lord, J. W.: Surgical Treatment of Essential Hypertension. *S. Clin. North America*, 28: 290-293, April, 1948.

cent to 19 per cent^{29,30} of reported cases show improvement with nephrectomy alone.

2. Hypertension is persistent (diastolic pressure remains above 90 at rest), there is no symptomatic improvement and there is progression of the disease under adequate medical treatment.

3. Associated cardiovascular involvement is not so great that it contraindicates surgery.

Prognostic tests: Prognostic tests such as the determination of blood pressure responses to postural changes and cold, to sedation, to administration of sympatholytic or ganglion blocking drugs such as 2-benzyl-imidazoline hydrochloride (Priscoline®) or tetraethylammonium chloride (Etamon Chloride®) and to caudal or spinal anesthesia are of little value in determining the response to surgical treatment.^{29,31-33}

Significance of blood pressure levels: Those individuals whose diastolic pressure fails to fall below 90 at rest are said to have persistent hypertension. Smithwick³⁴ believes that 95 per cent of those cases whose diastolic pressure fails to fall below 90 show evidence of cardiovascular damage.

In considering blood pressure levels one should also consider peaks of blood pressure elevation. These sharp overshoots of blood pressure greatly increase mechanical stress and strain to the cardiovascular system. Patients with labile blood pressure usually obtain better results from surgical treatment than individuals with fixed pressures. High pulse pressure is usually considered as an unfavorable indication for surgical treatment since it is usually due to diminished elasticity of larger vessels.

Cardiovascular changes: Evaluation of changes in eyes, brain, heart, and kidneys is the best guide in determination of indications and contraindications for surgical treatment.

Eye ground changes may be classified simply into four grades characterized by (1) normal fundi, or no more than arteriolar spasm; (2) arteriolar spasm, arteriovenous compression, tortuosity and increased light reflex; (3) presence of hemorrhage or exudate; (4) papilledema. Patients with Grade 1 fundi usually have mild hypertension and are rarely treated surgically. The majority of surgically

treated cases will have Grade 2 or 3 optic fundi. Progression of retinal changes may be the only indication of progression of the disease in some patients and thus serve as an indication for surgical treatment. Rapidly failing vision due to retinal vascular changes is an urgent indication for surgery. Eye ground changes in themselves do not contraindicate surgery although some feel that malignant hypertension (Grade 4 optic fundi) should not be treated surgically.^{17,26}

Cerebrovascular changes may be manifested only by attacks of hypertensive encephalopathy, which most consider an urgent indication. Hemiplegia, if recent, is a contraindication. Hemiplegia within three to six months and with no disabling residuals is usually considered an indication for surgical treatment. Evidence of mental deterioration is an absolute contraindication.

Evidence of cardiac damage such as increase in heart size, electrocardiographic evidence of left ventricular strain and attacks of cardiac decompensation, if the decompensation responds to treatment, is a most urgent indication for surgical treatment. Old myocardial infarction (six months previously) may not contraindicate surgery if the heart is well compensated. Recent myocardial infarction, obvious coronary insufficiency, congestive heart failure not responding to treatment, auricular fibrillation, flutter or heart block all contraindicate surgery.

Renal vascular damage, if very marked, is one of the most absolute contraindications to surgical treatment. Individuals with marked impairment of renal function (inability to concentrate urine to a specific gravity above 1.018, a PSP excretion of 15 per cent or less in fifteen minutes, urea clearance below 60 per cent of normal or N.P.N. of above 45) receive no benefit from surgery and incur a high immediate mortality. Nocturia, slight albuminuria and moderate functional impairment are not contraindications and may be improved after surgery.

Classification according to degree of cardiovascular damage: Classification of hypertension according to degree of cardiovascular involvement serves as an aid in the selection of cases for surgical treatment. Keith, Wagener and Barker¹¹ first classified hypertension into four groups largely on the basis of eye ground changes as discussed under cardiovascular changes.

This classification is used by many in selection of cases for surgical treatment but the extent of damage to heart, brain and kidneys is also taken into consideration. The Lahey Clinic report²¹ that they do not treat patients in Group 1 surgically. It is their opinion that patients over fifty in Groups 1 or 2, with long-standing hypertension, good renal function and no cardiac enlargement will live as

27. Linton, R. R., Moore, F. D., Simeone, F. A., Welch, C. E. and White, J. C.: Thoracolumbar Sympathectomy. *S. Clin. North Amer.*, 27:1178-1187, Oct., 1947.

28. White, J. C. and Smithwick, R. H.: *Autonomic Nervous System*. MacMillan Co., New York, 1941.

29. Goldring, W. and Chasis, H.: Sympathectomy and Unilateral Nephrectomy in Treatment of Hypertensive Disease. *M. Clin. North Amer.*, 33:751-771, May, 1949.

30. Bassett, R. C.: Present Status of Sympathectomy in Treatment of Hypertension. *M. Clin. North Amer.*, 32:187-195, Jan., 1948.

31. Smith, H. W.: Hypertension and Urologic Disease. *Am. J. Med.*, 4:724-743, May, 1948.

32. Findley, T.: Indications for Sympathectomy in Treatment of Hypertension. *Surgery*, 23:639, 1948.

33. Palmer, R. S.: Medical Evaluation of Surgical Treatment of Hypertension. *J. A. M. A.*, 134:9-14, May 3, 1947.

34. Hinton, J. W. and Lord, J. W., Jr.: Selection of Patients for Thoracolumbar Sympathectomy; Description of Set of Rules for Elimination of Failures and Fatalities. *Ann. Surg.*, 127:681-684, April, 1948.

long without surgical treatment. They believe that patients in Group 3 will be considerably benefited by surgical treatment and recommend surgery for patients in Group 4, with satisfactory renal function.

Peet¹⁵ divided his cases into six groups. Group 1: early mild asymptomatic hypertension with normal or Grade 1 optic fundi. Group 2: symptomatic hypertension with abnormal optic fundi, but no other organic disease. Groups 3, 4 and 5: cardiac, cerebrovascular and renal disease predominate respectively. Group 6: malignant hypertension manifested by papilledema of one diopter or more. Peet states that any patient under sixty, not in congestive heart failure, with N.P.N. below 45 and who has not had a major cerebrovascular accident during the previous month is a reasonable operative risk.

Hinton³¹ groups his cases according to a system of pluses, one to four plus representing degrees of involvement in each of the four systems: brain, heart, eyes, and kidneys. A four plus kidney rating; a four plus cardiac rating (if cardiac decompensation does not respond to treatment); a four plus cerebral rating (if confused or there has been a stroke within three months); two four pluses other than eye, or a total of eleven pluses contraindicate surgery.

Individual case selection: The young adult with persistent hypertension and minimal or no evidence of cardiovascular damage should be carefully followed under medical management. If there is progression as indicated by change in the optic fundi, brain, heart, or kidneys, surgery should be recommended.

The majority of cases selected for surgical treatment will be under fifty years of age and have persistent hypertension with symptoms and varying degrees of cardiovascular damage. Surgery should be recommended for all those in this group who fail to respond to medical treatment unless the cardiovascular damage is so extensive that little improvement can be expected. Surgery should also be considered if the medical regime required makes the patient a semi-invalid at the peak of his productive years.

Patients with malignant hypertension warrant special consideration. Many physicians have adopted a hopeless attitude toward this phase of the disease. The expected mortality in three years under medical treatment is 100 per cent.^{8,15} Peet¹⁵ reported 112 cases treated surgically with a mortality of 81 per cent in five to eleven years. Since no other treatment offers any hope for this condition, patients with satisfactory renal function should be offered the 20 per cent chance of five-year survival that can be expected from surgical treatment.

A serious problem is encountered in selection of patients over fifty years of age. Many feel that none of this group are candidates for surgery, because of

irreversible arteriosclerotic changes. Immediate operative mortality is also higher. However, there are patients over fifty with hypertension of short duration and minimal demonstrable arteriosclerotic changes. These individuals should be considered for surgery but should in general be subjected to less extensive procedures.

Some individuals who are totally incapacitated by headache, dizziness or failing vision warrant consideration for minimal surgical procedures solely for symptomatic relief, although there is no hope of prolongation of life.

TYPE OF OPERATION

Operations performed today in the treatment of hypertension are all splanchnicectomies. They differ only in technical approach (posterior supra-diaphragmatic, posterior dorsal lumbar, transthoracic retropleural, transpleural) and in the extent of sympathectomy performed. They are all bilateral procedures and are usually performed in two stages, ten days to two weeks apart.

At the present time Peet's group performs supra-diaphragmatic splanchnicectomy. In their earlier cases sympathectomy D9 to D12 was performed. They are now extending to D5 or higher.

Smithwick³ performs a lumbo-dorsal sympathectomy from D8 to L2 inclusively, except 15 per cent of his cases in which he does a subtotal or total thoracic sympathectomy. deTakats²⁶ performs the Smithwick lumbo-dorsal sympathectomy. Linton²⁷ does a sympathectomy from D6 to L3. He does a Peet procedure in poor risk cases. Hinton³¹ performs sympathectomy from D3 through L3 in younger individuals and from D8 through L2 in older patients. Grimson¹⁹ does a total thoracic and partial to total lumbar sympathectomy and celiac ganglionectomy.

Evaluation of extent of sympathectomy: Present evidence indicates that as near complete denervation of the splanchnic bed as possible gives the most beneficial and enduring results. The splanchnic bed receives sympathetic fibers from D6 to L2 and in some cases from D3 to L2 sympathetic ganglia.³⁵

A more widespread vasomotor paralysis may be obtained by increasing the extent of sympathectomy. There is a rough quantitative relationship between extent of sympathectomy and degree of lowering of blood pressure.³⁶ However, the small percentage of improved results between total sympathectomy and splanchnic denervation does not justify the increased morbidity and mortality in most cases.

35. Kuntz, A.: *Neuroanatomic Basis of Surgery for Autonomic Nervous System*. Chas. C. Thomas, Springfield, Ill., 1949.

36. Ray, B. S. and Console, A. D.: *Evaluation of Total Sympathectomy*. *Ann. Surg.*, 130:652-673, Oct., 1949.

Extent of the operative procedure must be varied in accordance with clinical evaluation of the patient. In younger individuals without extensive cardiovascular damage, the splanchnic bed should be denervated as completely as possible by splanchnicectomy and sympathectomy from D6 to L2. It is not justifiable to extend the sympathectomy above D6 routinely.

Older patients and those with more extensive cardiovascular damage are subject to higher mortality and morbidity if complete splanchnic denervation is done. Extent of the procedure must be varied for patients in this group. If cardiovascular damage is not too great a sympathectomy D8 to L2 may be performed. In those cases with more severe cardiovascular damage sympathectomy may be extended to L2 on one side only. In certain cases it will be wise to perform only supradiaphragmatic splanchnicectomy, D6 to D12.

Patients with preoperative postural tachycardia or persistent tachycardia will receive additional benefit from excision of cardiac accelerator fibers. In these cases sympathectomy from D2 to D12 may be performed. The same physiologic effect can be expected from this operation as from excision of ganglia D6 to L2.^{1,2} Some cases with anginal pain will receive additional benefit by removal of afferent cardiac pain fibers. In these cases total thoracic sympathectomy should be performed.

Certain other cases that have failed to respond to complete splanchnic denervation may be bene-

fited by increasing the sympathectomy to total or near total.

The lumbar ganglia must be preserved on one side in young males who desire children as bilateral removal of L1 results in loss of ejaculatory power in 60 per cent of cases.

SUMMARY

Comparison of mortality rates, blood pressure levels, decrease in heart size, improvement of abnormal electrocardiograms, renal function and retinal changes in medically and surgically treated patients indicates that prognosis for hypertension has been appreciably improved by surgical treatment of properly selected cases.

Hypertensive patients should be considered for surgical treatment if they meet the following qualifications: (1) they are true cases of essential hypertension; (2) their hypertension is persistent, there is no symptomatic improvement and there is progression under adequate medical treatment; (3) the associated cardiovascular involvement is not so great that it contraindicates surgery.

Contraindications to surgical treatment are: evidence of marked renal impairment, cerebral deterioration or severe cardiac damage.

Complete denervation of the splanchnic bed (D6 to L2) is the surgical procedure of choice in treatment of hypertension. However, in older patients and patients with extensive cardiovascular damage extent of sympathectomy should be modified according to clinical estimate.

CLINICAL MEDICINE...

PLACENTAL EXTRACT IN TREATMENT OF RHEUMATOID ARTHRITIS

ROLL NEWELL DILLON, M.D., and

JOHN J. MAJNARICH, B.S.

SEATTLE, WASH.

Hench¹ has shown that the symptoms of rheumatoid arthritis are modified in pregnancy. Granirer² has obtained similar results using postpartum blood serum on patients with rheumatoid arthritis. Tufts, Pessin and Greenwalt³ report the use of sterile placental and cord serum in a similar manner.

In this laboratory attempts have been made to concentrate the active factor or factors from placen-

tas as obtained from the hospital after delivery. In brief, the placentas were macerated and extracted with acetone. The aqueous acetone solution was evaporated in vacuo to remove the acetone. The aqueous material was then extracted with ethylene dichloride, concentrated in vacuo and prepared for injection. A 50- to 100-fold concentration based on the original starting material can be obtained. The material was assayed on normal mice for toxicity prior to clinical use. The results would seem to indicate that a highly active material is present, probably of an adrenocorticotrophic-like nature. The details of isolation and mouse assay are to be the subject of a full report.

This material, which we designate as Placental Extract, has been used on a total of sixteen patients. This case is reported only because it is the first case in which this placental extract has been used as the only form of treatment in an acute case of rheumatoid arthritis in our practice. It was felt that,

1. Hench, P. S.: Ameliorating Effect of Pregnancy on Chronic Atrophic (infectious rheumatoid) Arthritis, Fibrositis and Intermittent Hydrarthrosis, Proc. Staff Meeting May Clinic, 12:161-167, March 16, 1938.

2. Granirer, L. W.: Clinical Response of Rheumatoid Arthritis to Postpartum Plasma, a Two-year Study. J. Am. Med. Assoc., 146:995-997, July 14, 1951.

3. Tufts, M., Pessin, S. B. and Greenwalt, T.: Staff Meeting, Dec., 1950, St. Mary's Hospital, Milwaukee, Wis.

in view of the present intense interest in adrenocortico-like substances and their application in the treatment of this condition, the results on this single case might be of interest.

This patient, Mrs. G. H., age 42, a white bookkeeper, was first seen July 3, 1951, with a history of pain in the right shoulder since August of 1950, followed by pain in the ankles, knees and left shoulder. She was in acute discomfort and able to walk only if supported. She had been confined to bed for three weeks in March of 1951 for this condition and at that time was put on Cortisone orally in divided doses of 100 mg. daily. At first there was considerable relief. Apparently this dosage had been continued up to the time of her first visit. According to her own evaluation, she was definitely and rapidly "going down hill" as of her first visit to the office.

Previous history was non-contributory and non-illuminating.

Examination showed an acutely ill woman obviously in pain and quite markedly emaciated. The fingers showed the typical fusiform swelling of rheumatoid arthritis. The right knee was swollen to about twice the size of its mate, was hot and tender to palpation.

The patient was instructed to take no medication of any kind. A complete blood count, sedimentation rate and urinalysis was done and this repeated at weekly intervals. She was also instructed to report to the office twice weekly for treatment. The laboratory reports are summarized in Table I.

At the end of the first week the patient volunteered that she had definitely less pain and clinically she seemed improved. At the end of the second week, while the patient insisted she felt better clinically, she did not appear as well or as comfortable as previously, and this impression is borne out in the laboratory report. On July 20, two and one-half weeks after initiation of treatment, the patient's evaluation of her condition was that she felt very much better and was able to move around so much better and do little things which she had not been able to do before.

She also stated her legs were relaxed as they had not been for a long time. In general, her clinical condition has closely approximated the course of her leucocyte count and sedimentation rate, although despite the fluctuations she has insisted that at all times she has been subjectively improved.

Placental Extract has been used on a series of sixteen rheumatoid arthritics, but until the above reported case, never to the exclusion of any other treatment. Results were encouraging in most cases. Two other cases are also under treatment with only Placental Extract and their response has closely approximated the case reported. It is planned to run a series of cases using only the Placental Extract in their treatment and it is hoped that this will be the subject of a further report.

TABLE I
LABORATORY REPORTS OF MRS. G. H.
Sedimentation
Rate
(Westergren)
Date Mm. per hr. Hbg. Gms. Erythrocyte Count Millions Leucocyte Count

Date	Mm. per hr.	Hbg. Gms.	Erythrocyte Count Millions	Leucocyte Count
7-3-51	96	12.5	4.33	17,000
7-10-51	64	13.0	4.43	11,400
7-17-51	91	13.0	4.36	13,000
7-20-51	41	13.5	4.58	10,800
7-24-51	39	13.5	4.67	10,500

LATE RH SENSITIZATION*

PAUL R. ROLLINS, M.D.

SEATTLE, WASH.

IT IS USUALLY assumed that if an Rh negative woman has not become immunized by her fifth pregnancy that future immunization will not occur; also, that if an Rh negative woman bears an infant which dies of erythroblastosis, all subsequent children (unless Rh negative) born of this union will likewise die of erythroblastosis. This brief case report illustrates an exception to both of these beliefs.

This patient, a gravida X, Rh neg., age 38, was first seen December 2, 1949, her last menstrual period being September 19, 1949. Her due date was June 17, 1950. She had one child by her first husband (whose Rh is unknown) and nine pregnancies by her second husband who is homozygous Rh positive. Following the birth of five normal full-term children, she became pregnant for the seventh time and five years ago delivered a full-term, 8-pound infant which lived three days, dying with petechial spots and jaundice. One year later she had a full-term infant weighing 8 pounds 2 ounces which survived after repeated transfusions during the first two weeks of life. This infant also showing jaundice and petechiae. Two years ago she had a macerated stillborn at term, no fetal movement having been noted during the last week of pregnancy.

During this present pregnancy, she had been seen previously by two physicians, both of whom had advised therapeutic abortion, one on the basis of a titre of 1:8900. She realized that chances for survival of this infant were poor but felt that this child "had as much right to life as any of her others." It was difficult for her to report for prenatal examinations and only two titres were obtained; one at 33 weeks gestation showing blocking antibody titre 64 and one at 36 weeks gestation showing no agglutinating antibodies, blocking 1:2. On May 23, when 37 weeks pregnant, she called saying the baby was suddenly much less active and reminding me that with her previous pregnancy this had happened the day before fetal movement ceased. Accordingly, I advised her to go to the hospital where a vaginal examination showed the head to be floating and the cervix long, firm and closed. Because of her previous experience she was most insistent that the baby be delivered and her request seemed a reasonable one. Since she was not inducible, a caesarean section was done, followed by a supravaginal hysterectomy. Her convalescence was uneventful and she was discharged on the seventh day.

The baby weighed 7 pounds 5 ounces, showed no edema, jaundice or splenic enlargement, the cry was vigorous and the color was good. Cord blood: Hgb. 11 gms., RBC 3,000,000, WBC 7,620, 89 nucleated RBC/100 WBC., Combs test positive, Blood Type A, Rh positive. Two hours after birth a replacement transfusion was given withdrawing 275 cc. and giving 345 cc. of Rh negative, female blood. This procedure was tolerated well. The following day the nucleated RBC were 8/100 WBC and disappeared two days later. The daily hemoglobin during hospital stay varied from 11.8-13.5 gms., and no further transfusions have since been given. His subsequent course has been satisfactory.

Attempts at preventing hemolytic disease in infants of immunized Rh neg. women have not been particularly successful, but it is worth while to

* Read before the annual meeting of the Seattle Surgical Society, Seattle, Wash., Feb. 2-3, 1951.

record briefly some of the therapeutic methods which have been recommended.

(a) Vitamin C was advocated by Burnham¹ to increase capillary integrity and decrease leakage of cells from the vessels of the villi.

(b) The addition of serum containing blocking antibodies to inhibit agglutinating antibodies was suggested by Diamond and Abelson,² but patients so treated were not benefited.

(c) The administration of protein-free Rh hapten, first isolated by Carter³ in 1946, has received considerable publicity. Goldsmith⁴ and others have reported cases successfully treated by the use of hapten, but most writers are inclined to doubt its value. However, it would seem to be the most promising line to pursue and perhaps a more purified or potent hapten will be the eventual therapy in this condition.

(d) Attempts at exhaustion of maternal agglutinins by repeated injections of small amounts of Rh positive blood as advised by Broman⁵ have thus far not been successful.

(e) Hoffman and Edwards⁶ report a fall in titre in immunized patients by using a combination of Vitamin K and progesterone. In 50 treated patients, none delivered an erythroblastotic infant or an infant with an erythroblast count; none developed antibodies and those with antibodies showed a diminution or disappearance of antibodies under treatment.

(f) Caesarean section is to be avoided in the termination of these pregnancies although in the present patient a good outcome resulted. Too often the additional factor of prematurity is added to the erythroblastosis with a fatal termination. Indeed, Potter⁷ says that "in no instance when a mother has previously lost an infant from hemolytic disease have we obtained an infant by caesarean section who survived and was normal." Philpott and others, however, believe that section is to be considered in patients beyond the thirty-sixth week with a rising titre in whom labor cannot be induced.

SUMMARY

1. A patient is presented who has two surviving children subsequent to the delivery of an infant dying of erythroblastosis.

2. Therapeutic abortion is not indicated in Rh negative women who have lost a child from erythroblastosis, nor is it indicated on the basis of a high blood titre (titres above 1:100 are believed by some to indicate fetal involvement).

3. In general, these pregnancies should not be terminated by caesarean section, but an occasional case may indicate its use.

4. The treatment of Rh negative, immune pregnant women has thus far not been very successful. Promising therapeutic trends have been indicated.

ACUTE TOXIC PSYCHOSIS FOLLOWING CORTISONE

HARVEY A. HATCH, M.D.

IDAHO FALLS, IDA.

THE following case is submitted because of the relatively small dose of cortisone administered and because of the dramatic association of psychosis with its use.

A 35-year-old male was given 400,000 u. aqueous penicillin November 15, 1950, for acute pharyngitis. On November 24 he developed large angioneurotic plaques on the groin, face, neck and back. He was given 100 mgm. cortisone, 1 cc. of epinephrine in oil, ephedrine $\frac{3}{4}$ gr. capsules and sent to bed. Seconal, $1\frac{1}{2}$ gr. was given during the night. He had used Seconal before uneventfully. On November 25 he was given 100 mg. more of cortisone. On November 26 his hives diminished but in mid-morning he suddenly became delirious. He was disoriented as to time. He thought events of one year had occurred the night before. There was no fever. His thoughts flitted from one subject to another with no apparent relationship. He recognized those around him and remembered recent events. He would cry violently for a second or two or would suddenly thrash wildly about. For a few minutes he would lie quietly and seem to be sleeping, but such periods were short. He was hospitalized for observation and treatment. While hospitalized, fluids were forced and he was given sedation. No other medications were given. His mental abnormality persisted and he began to show extreme sensitivity to light and to sound. He also became sensitive to tactile sensations and complained when touched.

During the first night of hospitalization, he slept very little. The following day he was very much the same with perhaps a little less irritability and a little better memory for recent events. He was still unable to follow continuous thought for more than a few moments. His skin condition cleared considerably during the second day. On the second evening of hospitalization he became fairly clear and all replies were rational. He continued to be somewhat sensitive to light and sound and was restless and sleepless. The next day his mind was completely clear and his skin was also practically clear. He was observed for another 24 hours during which time he slept considerably without sedation but was otherwise normal.

There had been no previous episodes of a similar nature in his life. He had always been well integrated and oriented.

1. Burnham, L.: Vitamin C Deficiency as Possible Factor in Pathogenesis of Erythroblastosis Fetalis. *Am. J. Obst. & Gynec.*, 44:920-921, Nov. 1, 1942.

2. Diamond, L. K. and Abelson, N. M.: Importance of Rh Inhibitor Substance in Anti-Rh Serums. *J. Clin. Investigation*, 24:122-126, Jan., 1945.

3. Carter, B. B.: Preliminary Report on Substance Which Inhibits Anti-Rh Serum. *Am. J. Clin. Path.*, 17:646-649, Oct., 1947.

4. Goldsmith, J. W.: Experiences With Rh Hapten. *Am. J. Obst. & Gynec.*, 50:172-177, Jan., 1950.

5. Broman, B.: Blood Factor Rh in Man; Clinico-Serological Investigation with Special Regard to Morbus Haemolyticus Neonatorum ("Erythroblastosis Foetalis"). *Acta Paediat.* (suppl. 2), 31:1-178, 1944.

6. Hoffman, P. B. and Edwards, D. W.: Preliminary Report on a New Concept in Treatment of Rh-Negative Pregnant Women. *Am. J. Obst. & Gynec.*, 50:207-209, Jan., 1950.

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Summary: Injection of 200 mg. of cortisone in two doses 24 hours apart was followed in 12 hours by an acute toxic psychosis which lasted almost three days.

It is not known definitely that cortisone was the cause of this episode, but, in view of the close association with its use, it was felt advisable to report this case.

RECTAL BLEEDING DUE TO ENDOMETRIOSIS*

EVERETT B. COULTER, M.D., and

TED E. LUDDEN, M.D.

SPOKANE, WASH.

RECTAL BLEEDING from endometriosis has been reported rarely.^{1,2} The following case report is presented because of its rarity:

CLINICAL DATA

A 35-year-old married female with two children was admitted to Deaconess Hospital, Spokane, Dec. 13, 1949. She had bled from the bowel during menstrual periods for the preceding four months. Bleeding was bright red and continued from one to two days. She passed about one-half ounce of blood with each bowel movement. She noted an increase in mucus in her bowel movements during the entire four or five days of her period. During periods bowel movements were painful and number of movements increased. She had undergone an operation elsewhere in June, 1944. At this time the left ovary and tube, a small uterine leiomyoma and the appendix were removed.

One week prior to admission the patient was explored elsewhere, the preoperative diagnosis being fibroid of the uterus. A constricting lesion of the sigmoid colon assumed to be carcinoma was found at this operation but, because of lack of facilities, no attempt was made to resect the bowel at that time. On rectal examination a mass could be felt between the rectum and the uterus. This was thought to be in the wall of the bowel. Protoscopic examination was negative to 15 cm. A small amount of bleeding was noted when the sigmoidoscope was withdrawn.

On Dec. 14, 1949, a second laparotomy was performed. A constricting lesion of the lower portion of the sigmoid colon, measuring about 5 cm. in maximum diameter, was found. Grossly this resembled a carcinoma of the bowel but frozen sections showed it to be composed of endometrial type glands and stroma situated in fibrous tissue. Segmental resection of the involved portion of the colon was done.

Excised portion of colon measured 15.0 cm. in length. At approximately midportion of the specimen its serosa appeared to be extensively fibrotic and there was marked angulation of the bowel with resulting obstruction of its lumen. Mucosal aspect of the angu-

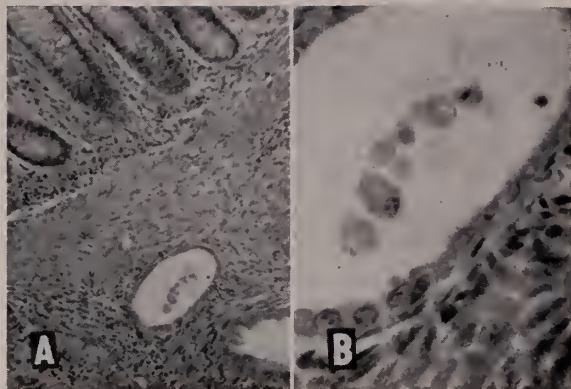


Fig. 1. Sigmoid Colon: (a) The glandular structures in the lower portion of the field are lined by endometrial-type epithelium and are partially surrounded by endometrial-type stroma (H. and E., X 150); (b) Higher magnification of the endometrial-type glandular structures shown in (a). The endometrial-type stroma is well illustrated (H. and E., X 660).

lated area presented two dark red hemorrhagic appearing lesions, each measuring about 0.4 cm. in diameter.

Histologic sections showed the fibrous appearing tissue to be composed of densely arranged collagen and fibroblasts surrounding islands of endometrial type glands and stroma. Hemorrhagic appearing areas in the mucosa were composed of endometrial type glands and stroma (fig. 1a and 1b).

The patient convalesced satisfactorily. She had a normal bowel movement on the fifth postoperative day and was discharged on the sixth postoperative day. She has remained well until the present time.

COMMENT

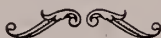
Principal point of interest in this case is that a mistaken gross diagnosis of carcinoma of the bowel was made. This is understandable since endometriosis may closely simulate carcinoma, even, as in this instance, causing rectal bleeding. In this connection it is of interest that of nine cases of intestinal endometriosis reported by Sutler³ three had been previously treated for carcinoma. The fact that rectal bleeding has rarely been reported in association with endometriosis should not cause one to minimize the frequency of this finding. If the possibility of endometriosis is borne in mind the potentially tragic mistake of performing an unnecessary radical procedure or of calling it inoperable carcinoma may be avoided. In this connection it should be mentioned that carcinoma and endometriosis may coexist and that as a consequence of this fact not all tissue which grossly resembles cancer, even in a patient with a histologic diagnosis, is necessarily malignant.

3. Sutler, Martin R.: Endometriosis of the Intestinal Tract. *Surg.*, 22:801-805, Nov., 1947.

* Reported from the Departments of Surgery and Pathology, Deaconess Hospital, Spokane, Washington.

1. McGuff, Paul, Dockerty, Malcolm B., Waugh, John M. and Randall, Lawrence M.: Endometriosis as a Cause of Intestinal Obstruction. *S. G. O.*, 86:273-288, March, 1948.

2. Thierstein, Samuel T. and Allen, Edward: Comparative Analysis of Diagnosis and Treatment of Endometriosis, Including Report of Fifty-three Cases of Intestinal Endometriosis. *Am. J. Obst. & Gynec.*, 51:635-642, May, 1946.



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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

77th Annual Session

Oregon State Medical Society

PRESIDENT WILLIAM J. WEESE KEYNOTES ONE OF MOST INTERESTING SESSIONS IN HISTORY OF OREGON STATE MEDICAL SOCIETY

In his annual message to members of the Society, President William J. Weese predicted the 77th Annual Session will be outstanding in its broad interest to members.

The three and one-half day meeting will convene on Wednesday, October 10, at the Masonic Temple, Portland, Oregon, and will conclude with the half-day session on Saturday, October 13.

President's Message

THROUGH the courtesy of the Trustee of the Sommer Memorial Fund and the Advisory Committee to the Fund consisting of Frank R. Menne, Ralph A. Fenton and Eugene W. Rockey of Portland and Donald V. Trueblood of Seattle, the 14th Lecture Series will be held in conjunction with the meeting. Three distinguished guest lecturers will each present three timely and instructive papers.

John W. Cline, San Francisco Surgeon and President of the American Medical Association, will also be a guest lecturer and the chief speaker at the annual banquet.

In addition, the various departments of the University of Oregon Medical School have arranged a coordinated program of papers, panel discussions, and demonstrations covering recent advances in their respective fields. Thus, the scientific program will offer a broad and well-rounded "refresher" course for the busy physician.

The Scientific Exhibit has become an important educational feature of our annual session. This year, a large number of institutions, official and voluntary health agencies, professional schools and societies, as well as individual physicians will present exhibits of great interest and value.

Likewise, the Technical Exhibit is primarily educational in nature. Some fifty firms which serve the medical profession will have attractive and informative displays of the latest drugs, instruments, apparatus, books, and many other items.

Numerous important matters of policy will be considered by our legislative body, the House of Delegates. The actions of the House of Delegates are of vital concern to the entire membership. All members are invited and urged to attend the daily breakfast meetings of the House.

The Woman's Auxiliary will hold its Annual Fall Session in conjunction with our meeting. The Auxiliary has become an indispensable adjunct of the Society and merits our full support. Be sure to bring your wife and urge her to attend and participate in the Auxiliary meetings and social events. She will be especially interested in meeting the National Auxiliary President, Mrs. Harold F. Wahlquist of Minneapolis, Minnesota.

The social aspect of our annual session is vital to the stimulation of closer personal relationships among our members. Every meeting offers the opportunity to make new friendships and renew the old. Chief social



WILLIAM J. WEESE, M.D.
Ontario

President, Oregon State Medical Society

event of the session will be the annual banquet at which the Society will honor Executive Secretary Mr. Clyde C. Foley on the occasion of the completion of his twenty-fifth year of service. John H. Fitzgibbon will be toastmaster and John W. Cline will be the guest speaker.

Also high on the recreational calendar is the Oregon-Washington football game on Saturday, October 13. Regardless of pre-season estimates of their relative strength, these traditional rivals always produce an interesting contest.

A special invitation to attend the session is extended to the many new members who have affiliated with the Society during the past year. We appreciate this opportunity to welcome them into our state organization.

We shall cordially welcome to our meeting the members of our sister state medical associations in Washington and Idaho and hope that many of them will attend.

See you in Portland next month!

Sincerely,

WILLIAM J. WEESE, M.D., *President*
Oregon State Medical Society

Honoring Clyde Cowie Foley

Twenty-five years of devotion to interests of the medical profession will be noted by the Oregon State Medical Society when it honors Mr. Clyde C. Foley at the annual banquet October 12.

It is altogether fitting that he should be so honored. Those who know Clyde and who have worked closely with him have long since placed him permanently in the honors column. His intimate knowledge of medical affairs coupled with his sound and mature judgment have earned the respect of all who know him. His steadfast devotion to the cause which he took up a quarter of a century ago has added to that respect and admiration.

Keen discernment and able mind, however, do not entirely explain the position which Clyde Foley has attained. His character, as well as his accomplishments, has stimulated not only respect but also a warmth of personal affection which is given to few men.

The Oregon State Medical Society has learned to rely heavily on the knowledge, judgment and abilities of its executive secretary. Its great debt to Mr. Foley will be recognized when he is honored October 12.



A. M. A. President to Be Featured Guest

IT HAS been many years since the Oregon State Medical Society has been honored by a visit from the A. M. A. President during his term of office. The presence of John W. Cline at the Annual Session will be both interesting and instructive to members.



JOHN W. CLINE, M.D.
President
American Medical Association

Dr. Cline will participate in both the general and scientific program. He will deliver a paper at the Scientific Session, he will address the Woman's Auxiliary, and will be guest speaker at the annual banquet on Friday evening, October 12.

Dr. Cline has had a brilliant career of service to medicine. He served as a member of the House of Delegates of the American Medical Association from 1945 to 1950. He was delegate to the World Medical Association in 1948 and 1949. Previously he had

been President of the San Francisco County Medical Society and the California Medical Association.

A native Californian, Dr. Cline received his A.B. degree in 1921 at the University of California, where he served as student body president. He obtained his M.D. degree at Harvard Medical School in 1925. He was surgical house officer at the Massachusetts General Hospital during the next two years and a resident surgeon at Bellevue Hospital, New York, for the following two years.

In 1929, Dr. Cline entered the practice of surgery in San Francisco. He now is associate Clinical Professor of Surgery at Stanford University School of Medicine; Surgeon to the Stanford, San Francisco, and Children's Hospitals; and Surgical Consultant to the Biggs-Gridley Memorial Hospital. He is also Expert Medical Consultant in Surgery to the United States Air Force and consultant to the Surgeon General of the United States Navy.

Dr. Cline's professional society affiliations include membership in the San Francisco Surgical Society, which he has served as President; the California Academy of Medicine; the Pacific Coast Surgical Association; Fellowship in the American College of Surgeons, and Honorary Fellowship in the International College of Surgeons. He is a Diplomate of the American Board of Surgery.

His broad public interests are indicated by his current service as Secretary of the California Division of the American Cancer Society and as a member of the Board of Trustees of St. Francis Memorial Hospital.

HOTEL RESERVATIONS

All the principal hotels, except the Mallory and Multnomah Hotels, have set aside accommodations for the session. Reservations are being handled by the Society office, Medical-Dental Building, Portland 5. Application forms have been mailed to all members. Members of other state medical associations may obtain application forms by writing to the Society AT ONCE.

PROGRAM

Seventy-seventh Annual Session Oregon State Medical Society

Wednesday, October 10

- 7:00 Breakfast Meeting of House of Delegates
Dining Room, Heathman Hotel
All members are invited to attend
- 9:00 Registration—Masonic Temple

Morning Session • Commandery Room, Masonic Temple

- WILLIAM J. WEESE, Ontario, or
JOHN G. P. CLELAND, Oregon City, Presiding
- 10:00 Sommer Memorial Lecture—"Preventive
Pediatrics—Mid-Century Version"
Charles A. Janeway, Boston
- 11:00 "Erythroblastosis Fetalis"
Scott H. Goodnight, Portland
- 11:20 "Neonatal Renal Physiology: Its Importance
in the Administration of Fluids"
James P. Whittemore, Portland



CHARLES A. JANEWAY, M.D.
Boston, Massachusetts
Pediatrics

Charles A. Janeway, Thomas Morgan Rotch Professor of Pediatrics at Harvard Medical School, will bring to our members the benefits of his broad experience in medical research in his specialty. Dr. Janeway's investigations have been concerned with four main fields—infectious diseases, clinical use of blood derivatives, kidney disease, especially nephrosis in childhood, and experimental clinical studies of diseases of hypersensitivity.

Evening Session • Library Auditorium, University of Oregon Medical School

- WILLIAM J. WEESE, Ontario, or
JOHN G. P. CLELAND, Oregon City, Presiding
- 3:00 Sommer Memorial Lecture: "Gastric Pain"
F. H. Bentley, London
- 9:00 Meeting of Cooperating Physicians of the
Oregon Physicians' Service
Library Auditorium, U. of Ore. Medical School

Arch O. Pitman Will Conduct House of Delegates Meetings

ARCH O. PITMAN, Speaker of the House of Delegates, is completing his first, and very successful, year in office.



ARCH O. PITMAN, M.D.

Dr. Pitman will conduct the four breakfast meetings at the Annual Session. The meetings will convene daily at 7:00 a. m. in the dining room of Hotel Heathman. Members will hear annual reports of officers and committees, and will give consideration to matters of fundamental policy.

Dr. Pitman served as Vice-Speaker during the 1949-50 year. He was also the Society's Treasurer for one year, having been elected at the 1948 session in Medford. In addition to his Society office, he is a member of the Board of Directors of Oregon Physicians' Service.

Afternoon Session • Commandery Room, Masonic Temple

- WILLIAM J. WEESE, Ontario, or
JOHN G. P. CLELAND, Oregon City, Presiding
- 1:00 Sommer Memorial Lecture: "The Nephrotic Syndrome: An Important Chronic Disease Problem in Children"
Charles A. Janeway, Boston
- 2:00 Panel Discussion: "Care of the Premature"
Panel Members:
S. Gorham Babson, Portland, Moderator
J. Oppie McCall, Portland
Edgar M. Rector, Portland
Lendon H. Smith, Portland
- 3:00 Recess to Visit Scientific and Technical Exhibits
- 3:30 "Retrolental Fibroplasia"
Thomas E. Talbot, Portland
- 3:50 "The Late Prognosis of Prematurity"
Charles Bradley, Portland
- 4:10 Kodachrome Clinic:
"Dermatological Malignancies"
Joyle Dahl, Portland
- 6:00 Dinner Meeting and Annual Business Session of the Oregon Academy of General Practice
Mallory Hotel

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PROGRAM

Seventy-seventh Annual Session—Oregon State Medical Society

(Continued)

Thursday, October 11

7:00 Breakfast Meeting of House of Delegates
Dining Room, Heathman Hotel
All members are invited to attend

Morning Session • Commandery Room, Masonic Temple

- WILLIAM J. WEESE, Ontario, or
JOHN G. P. CLELAND, Oregon City, Presiding
- 8:30 "Shock Mechanisms"
Clare G. Peterson, Portland
- 8:50 "Medical Aspects of Shock"
Philip Selling, Portland
- 9:10 Sommer Memorial Lecture: "Blood and Blood Derivatives"
Charles A. Janeway, Boston
- 10:10 Recess to Visit Scientific and Technical Exhibits
- 10:40 "Whole Blood Transfusion Problems"
John A. Newman and
Raymond D. Grondahl, Portland
- 11:00 "Renal Responses in Shock"
Clarence V. Hodges, Portland



F. H. BENTLEY, M.D.
London, England
Gastric Surgery

During World War II, Professor Bentley served with the Royal Army Medical Corps in the Mediterranean theatre and on missions to the Russian army in Rumania and the Partisan army in Jugoslavia. He has spent the post-war years developing a clinical and surgical research department at the University of Durham Medical School and Teaching Hospital and will report on the interesting work being done there in his presentations at the Session.

Afternoon Session • Commandery Room, Masonic Temple

- WILLIAM J. WEESE, Ontario, or
JOHN G. P. CLELAND, Oregon City, Presiding
- 1:00 Sommer Memorial Lecture: "Clinical Aspects of the Blood Supply of the Stomach"
F. H. Bentley, London
- 2:00 Panel Discussion: "Shock and Its Aftermath"
Panel Members:
William K. Livingston, Portland, Moderator
Clare G. Peterson, Portland
Philip Selling, Portland
John A. Newman, Portland
Clarence V. Hodges, Portland
John O. Branford, Portland
- 3:00 Recess to Visit Scientific and Technical Exhibits
- 3:30 "Doctor—Here's Your Assignment in Civil Defense"
Robert M. Heilman, Portland
- 3:50 Kodachrome Clinic: "Common Dermatoses"
Thomas S. Saunders, Portland
- 4:10 Sommer Memorial Lecture: "Gastric Surgery"
F. H. Bentley, London

Evening Session • Library Auditorium, University of Oregon Medical School

- WILLIAM J. WEESE, Ontario, or
JOHN G. P. CLELAND, Oregon City, Presiding
- 8:00 Sommer Memorial Lecture: "Urinary Incontinence: Etiology and Treatment"
Virgil S. Counsellor, Rochester
- 9:00 "Common Lesions of the Breast"
John W. Cline, San Francisco

Sommer Memorial Lectures

FOR the first time since their inauguration in 1941, the Sommer Memorial Lectures will present the fall series as a part of the 77th Annual Session of the Oregon State Medical Society. This correlation of the two meetings is well in keeping with the desire of the late Ernst A. Sommer to promote the welfare and scientific knowledge of his chosen profession.



ERNST AUGUST SOMMER
1869 - 1936

The story of the life of Dr. Sommer is a clear reflection of humanitarian ideals, devotion to the medical profession, and a profound interest in the welfare of the individual.

The perpetual endowment fund which has made the Sommer Memorial Lectures possible is evidence of his altruistic vision. It is interesting to note his keen perception of changing times, for he reposed broad discretion in his Trustee and Advisory Committee to conduct the lectures in the face of varying conditions. His paramount objective was advancement of medical science—not "fad and fancy," but "sound scientific and clinical facts, known for their practicability to the profession."

And so the members attending this 77th Annual Session will hear three distinguished members of the medical profession under the auspices of the 14th Sommer Memorial Lectures: Charles A. Janeway, Pediatrics, Boston, Massachusetts; Virgil S. Counsellor, Gynecological Surgery, Rochester, Minnesota; and F. H. Bentley, Gastric Surgery, London, England. Their papers, together with the coordinated scientific program of the University of Oregon Medical School, will most certainly result in an outstanding tribute to the wisdom and forethought of Ernst A. Sommer.



PROGRAM

Seventy-seventh Annual Session—Oregon State Medical Society

(Continued)

Friday, October 12

- 7:00 Breakfast Meeting of House of Delegates
Dining Room, Heathman Hotel
All members are invited to attend

Morning Session • Commandery Room, Masonic Temple

- WILLIAM J. WEESE, Ontario, or
JOHN G. P. CLELAND, Oregon City, Presiding
- 8:30 "Placenta Previa"
Duncan R. Neilson, Portland
- 8:50 "Total Abdominal Hysterectomy"
Howard C. Stearns, Portland
- 9:10 Sommer Memorial Lecture: "Vaginal Hysterectomy: Indications, Advantages and Surgical Technic"
Virgil S. Counsellor, Rochester
- 10:10 Recess to Visit Scientific and Technical Exhibits
- 10:40 "Preeclampsia"
J. Oppie McCall, Portland
- 11:00 "Diagnosis of Cervical and Corpus Cancer with Fundamentals of Therapy"
Melvin W. Breese, Portland



VIRGIL S. COUNSELLOR, M.D.
Rochester, Minnesota
Gynecological Surgery

Dr. Virgil S. Counsellor graduated from Rush Medical College in 1920 and completed a Fellowship in Surgery at the Mayo Foundation in 1927. The following year he became Head of the Section on General Surgery at the Mayo Clinic. In 1946 he was appointed Senior Gynecological Surgeon. He is now Head, Section on General and Gynecologic Surgery, Mayo Clinic, and Professor of Surgery, Mayo Foundation.

Afternoon Session • Commandery Room, Masonic Temple

- WILLIAM J. WEESE, Ontario, or
JOHN G. P. CLELAND, Oregon City, Presiding
- 1:00 Sommer Memorial Lecture: "Vesical Fistulas: Etiology and Treatment"
Virgil S. Counsellor, Rochester
- 2:00 Panel Discussion: "Essentials of Prenatal Care"
Panel Members:
Clifford L. Fearl, Portland, Moderator
William O. Thomas, Portland
Kenneth J. Scales, Portland
Max H. Parrott, Portland
- 3:00 Recess to Visit Scientific and Technical Exhibits
- 3:30 "Practical Aspects of Breast Pathology"
Frank R. Menne and
Joseph E. Nohlgren, Portland
- 3:50 "Modern Therapy of Convulsive Disorders"
Richard R. Carter, Portland
- 4:10 "Indications for the Medical or Surgical Management of Gastric Hemorrhage"
John H. Fitzgibbon, Portland
- 6:00 Cocktail Hour
Emerald Room, Hotel Multnomah

- 7:00 Annual Banquet (Formal Dress Optional)
Grand Ballroom, Hotel Multnomah
Address: "The Problems Confronting Medicine in the Immediate Future"
John W. Cline, President,
American Medical Association

Saturday, October 13

- 7:00 Breakfast Meeting of House of Delegates
Dining Room, Heathman Hotel
All members are invited to attend
- 9:00 Annual Business Meeting & Election of Officers
Commandery Room, Masonic Temple

Morning Session • Commandery Room, Masonic Temple

- WILLIAM J. WEESE, Ontario, or
JOHN G. P. CLELAND, Oregon City, Presiding
- 9:30 "The Present Status of ACTH and Cortisone Therapy"
Daniel H. Labby, Portland
- 9:50 "Ion Exchange Resins and Other Measures Used in the Control of Edema"
Herbert E. Griswold, Portland
- 10:10 Recess
- 10:30 Panel Discussion: "Infectious Diseases and the Proper Use of Antibiotics"
Panel Members:
Arthur W. Frisch, Portland, Moderator
Clarence V. Hodges, Portland
John F. Higginson, Portland
Allan J. Hill, Jr., Portland
Morton J. Goodman, Portland

Football Game

- 1:30 Univ. of Oregon vs. Univ. of Washington
Multnomah Stadium

Retiring President Has Notable Career of Service

WILLIAM J. WEESE'S service as President climaxes a long and active career as a leader in medical organization. He has served as First Vice-President of the State Society and as Councilor for the Eastern Oregon District. Dr. Weese has also held the office of President of the Malheur County Medical Society and the Eastern Oregon District Medical Society.

Dr. Weese has served as City Health Officer for Ontario and has devoted much effort to the establishment of a full-time county health department in Malheur County, which was accomplished in 1948. He has been a member of the Oregon State Board of Health and served as its Vice-President.

Dr. Weese has long been concerned with the improvement of rural medical service. When the State Society established a Committee on Rural Medical Service in 1946, he was appointed Chairman and continued to serve in this capacity until he was inducted as President of the Society in 1950. His work on this Committee received national recognition in 1949, when he was appointed a member of the Committee on Rural Medical Service of the American Medical Association. In this capacity, Dr. Weese is charged with the responsibility of assisting to promote the activities of the Committees on Rural Medical Service of the State Medical Associations in the three Pacific Northwest states.

Blair Holcomb to Be 78th President

BLAIR HOLCOMB of Portland will be installed as the 78th President of the Society at the annual banquet.

Dr. Holcomb has been an active figure in the affairs of organized medicine in Oregon for many years.



BLAIR HOLCOMB, M.D.
President-Elect
Oregon State Medical Society

He has served as Secretary of the State Society and as Councilor. He was the first Speaker of the House of Delegates when that office was created in 1947 and served continuously until his election as President-Elect in 1950.

Dr. Holcomb was President of the Multnomah County Medical Society in 1945. He was instrumental in the organization of the Multnomah County Health Council.

He has been active in the American Diabetes Association and is a member of its Council. Dr. Holcomb is also a member of the Association's Committee on Diabetes Detection and was chairman of the first special Committee on Diabetes of the Oregon State Medical Society appointed to conduct the activities of National Diabetes Detection Week in Oregon.

Dr. Holcomb is Clinical Professor of Medicine and Head of the Division of Diabetes and Metabolism at the University of Oregon Medical School.



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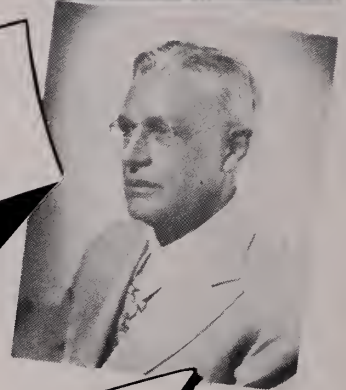
<i>Indications</i>	<i>Results</i>
CHRONIC APATHY	ELEVATION OF MOOD
CHRONIC ALCOHOLISM	IMPROVEMENT
ACUTE ALCOHOLISM	GOOD
NARCOLEPSY	MARKED IMPROVEMENT
BARBITURATE POISONING	EXCELLENT
WEIGHT REDUCTION	EXCELLENT
DYSMENORRHEA	MARKED IMPROVEMENT
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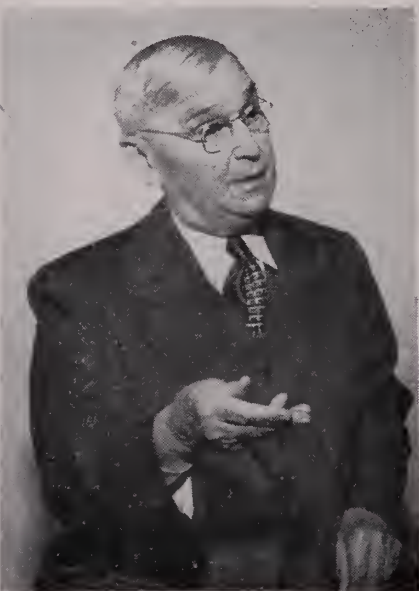


Famous "Ducks"



Then and Now

ABOVE and clockwise: R. M. McKeown; Lloyd Tegart; Lloyd Tegart, '16; Martin A. Haward; Ralph M. Dadson; W. H. Chapman; Horry L. Leavitt; Martin A. Howard, '21; Fred J. Ziegler.



Those Football Days at Oregon Are NOT Beyond Recall! Old Year-Books Prove That Some of Our Doctors DID Play Football . . .

IT IS INDEED FITTING that the 77th Annual Session should wind up with the University of Oregon-University of Washington football game. Both are honored and well-established institutions. They may be at cross-purposes with each other—the Annual Sessions are designed to further scientific and practical knowledge of medicine for the preservation of the human race, and the annual football game between these universities is conducted for the sole purpose of enabling one of the football elevens to annihilate the other in a business-like and orderly, albeit legal, fashion.

The first game between Oregon and Washington was played in 1900. Each year saw the spirit of competition grow, until we had a full-sized feud, which has delighted the hearts of spectators for lo, these many years. You never know whose apple cart will be upset. While Washington is being touted for the Pacific Coast Championship this year, there is always an element of suspense in this game. You just can't be too sure.

Well, we got to wondering if there might be some Oregon physicians who would have more than just a spectator's interest in this contest. The panorama of pictures at left is the result of our investigations.

This was not as easy as the picture page makes it look. Physicians are proverbially camera-shy, and we soon discovered that some of our football-playing doctors seemed to have jumped the gun. We didn't find one who had kept a scrapbook! However, we jugged a few memories, and came up with a few names. We called on Mr. L. H. Gregory, of the *Portland Oregonian*, and he very obligingly scoured the morgue for pictures and more information. Here are a few of the interesting bits we discovered.

Lloyd Tegart played his last game for Oregon in 1916. As a matter of fact, he played on the last championship team the U. of O. produced. (There is nothing in the record books to indicate that Dr. Tegart is in any way responsible for this unhappy fact, however.) The game that year between Washington and Oregon ended in a 0-0 tie, but Oregon went on to the Rose Bowl.

Martin Howard was a three-year letterman for Oregon. He played end, as did Dr. Tegart and, according to our information, was fast, hard-hitting and generally a rough character. He was mentioned, in 1921, on the mythical all-Coast eleven.

When we questioned Harry L. Leavitt in Seattle about his football career at the University of Oregon, he was very modest. He mumbled something about having played on the scrub team. However, our correspondents-at-large found that Dr. Leavitt was actually a two-year letterman back in 1926-27. He played guard. That, as you know, is the position which demands that you knock everyone down and trample them as soon as possible. Dr. Leavitt is now a very prominent orthopedic surgeon in Seattle. There is a tie-up here somewhere, but we aren't exactly sure what it is.

Fred Ziegler and Ralph M. Dodson played back in 1906, when men were men, and football was strictly a man's game.

About the others who played there is a certain aura of mystery. We have probably missed some. The important thing, however, is that the Oregon-Washington blood-letting is institutional. When you are enjoying the game on Saturday, October 13, remember that some of our distinguished Oregon physicians have made important and memorable contributions to the feuding and fussing!

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Scientific Exhibits

DUE to the unusual structure of this year's Annual Session, there has been no general call for scientific papers from members. However, the section of Scientific Exhibits has been set up to lend itself well to interesting and instructive material from many fields.

For instance, the University of Oregon Medical School has prepared an exhibit of great interest—an artificial mechanical kidney (Kolff type).

Also of interest will be the display arranged by E. W. Fowls and Albert L. Cooper featuring the use of plexiglas splints in the treatment of poliomyelitis.

There are many others of equal interest and value to members. Following is a list of the fine Scientific Exhibits members will have the opportunity of viewing:

1. "Anticholinergic Effects of Bladder Function"
Lowell W. Keizur, M.D., Florian J. Shasky, M.D., and Clarence V. Hodges, M.D., Department of Surgery, University of Oregon Medical School, Portland
2. "Artificial Mechanical Kidney (Kolff Type)"
Clarence V. Hodges, M.D., and Thomas R. Montgomery, M.D., Division of Urology, University of Oregon Medical School, Portland
3. "A Case of Musicogenic Epilepsy"
Robert S. Dow, M.D., Division of Neurology, University of Oregon Medical School, Portland
4. "Oregon Bone Tumor Registry"
Sheldon A. Jacobson, M.D., and George W. Cottrell, M.D., Department of Pathology, University of Oregon Medical School, Portland
5. "Medical Library Service"
Bertha B. Hallam, Librarian, University of Oregon Medical School, Portland
6. "Medical Illustration"
Clarice Ashworth, Medical Illustrator, University of Oregon Medical School, Portland
7. "Breast Cancer Can Be Controlled"
National Cancer Institute, Bethesda, Maryland
8. "Plexiglas Splints in Treatment of Poliomyelitis"
Everill W. Fowls, M.D., and Albert L. Cooper, M.D., Physical Medicine Rehabilitation Service, Veterans Administration Hospital, Portland
9. "Tumors of the Parotid Gland: Treatment, Pathology and Differential Diagnosis"
Robert A. Wise, M.D., Department of Surgery, Veterans Administration Hospital, Portland
10. "Radio-Active Iodine in the Diagnosis and Treatment of Thyroid Diseases"
Charles P. Wilson, M.D., Huldric Kammer, M.D., and William L. Lehman, M.D., Radio Isotope Committee, Good Samaritan Hospital, Portland
11. "Treatment of Alcoholism"
John D. Welch, M.D., The Retreat Hospital, Portland
12. "So-called 'Negative' Chest X-Rays in Serious Pulmonary Disease"
Lawrence M. Lowell, M.D., and John E. Tuhy, M.D., Portland
13. "Dental Caries Incidence in the Preschool Child" and "The Functions and Activities of the Child Study Clinic and Tumor Clinic"
William Davis, D.M.D., and Theodore Suher, D.M.D., University of Oregon Dental School, Portland
14. "Dental Health Service in the Portland Public Schools"
Willard H. Hurley, D.M.D., President, Oregon State Dental Association, and William L. Barnum, D.M.D., Supervisor, Dental Division, Portland Public Schools, Portland
15. "Your National Blood Program"
Nicholas P. Sullivan, M.D., Medical Director, Portland Regional Blood Center of the Multnomah County Chapter of the American National Red Cross and the Multnomah County Medical Society, Portland
16. "Vocational Rehabilitation in Oregon"
C. F. Feike, State Director, Division of Vocational Rehabilitation, Oregon State Board of Education, Salem
17. "Oregon School Activities Association Benefit Fund"
Thomas A. Pigott, Secretary-Treasurer, Oregon School Activities Association, Portland
18. "Oregon Physicians' Service—Your Prepaid Plan"
Lew Hurlbutt, Statistician, and Kenneth G. Manning, Promotion Supervisor, Portland
19. "The World Medical Association"
John H. Fitzgibbon, M.D., Portland
20. "Rehabilitation—Children and Adults"
Howard F. Feast, Executive Director, Oregon Society for Crippled Children and Adults, Portland
21. "Mental Health"
Melvin L. Murphy, Executive Director, Mental Health Association of Oregon, Portland
22. "TB Can Be Found and Cured"
Kenneth C. Ross, Executive Secretary, Oregon Tuberculosis and Health Association, Portland
23. "The Electronic Clinical Camera"
Mr. W. E. Bounds, Photronic, Incorporated, Portland

Technical Exhibit Largest on Record

A GAINST charming velour backdrops and set off by decorative panels, the largest technical exhibit in the history of Oregon's Annual Sessions may be viewed in the Sunken Ballroom at the Masonic Temple.

Below are the names of 50 firms who have reserved space for this exhibit. Their interest in the increasing importance of medicine in the Pacific Northwest deserves, in turn, the attention of members attending the session.

As added incentive to members, there will be valuable prizes for those who register at 75 per cent of the booths. This is an outstanding exhibit, and should have a record attendance.

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(Evaporated Milk Division)
Boyle and Company

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Carnation Company
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Ciba Pharmaceutical Products, Incorporated

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Corvek Medical Equipment Company
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The Doho Chemical Corporation
Eberhart X-Ray Company
C. B. Fleet Company
General Electric X-Ray Corporation
Haack Laboratories, Incorporated
Lanteen Medical Laboratories, Incorporated
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Eli Lilly and Company
M and R Dietetic Laboratories, Incorporated
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THE AUXILIARY GREETs MRS. HAROLD F. WAHLQUIST, NATIONAL AUXILIARY PRESIDENT

OUR AUXILIARY is honored by the presence of Mrs. Harold F. Wahlquist of Minneapolis, National Auxiliary President.

Mrs. Wahlquist was elevated to this highest office following long and meritorious service in the National Auxiliary and in her state and county organizations.



MRS. H. F. WAHLQUIST
National Auxiliary President

She has been a member of the Board of Directors of the National Auxiliary for the past ten years. She has also served as Treasurer, First Vice-President, Chairman of Public Relations, Chairman of the Finance Committee and a member of the Handbook and the Reading Committees.

Mrs. Wahlquist's activities in the Woman's Auxiliary to the Minnesota State Medical Association include service as Secretary, Corresponding Secretary, Treasurer, First, Second and Third Vice-President and President. She has also been a member of

the State Auxiliary Advisory Committee and the Exhibits Committee. Mrs. Wahlquist has also served as Vice-President and President of the Woman's Auxiliary to the Hennepin County Medical Society. For many years she has been vitally interested in the rural area Health Day movement in Minnesota, having initiated the idea among medical auxiliaries.

Mrs. Wahlquist has been an enthusiastic worker in voluntary health organizations. As Minneapolis Commander of the Field Army of the American Cancer Society, Mrs. Wahlquist organized the first Cancer Control campaign in Minneapolis. She also served as a member of the Board of the Minnesota Division of the American Cancer Society and was State Essay and Poster Chairman.

Mrs. Wahlquist was formerly a member of the Speakers Bureau of the Hennepin County Tuberculosis Association and several years ago served as Vice-Chairman of the Minneapolis Residential Division of the American Red Cross.

She has also devoted much time to other community organizations. Mrs. Wahlquist has been Vice-President and a member of the Board of the Minneapolis Y. W. C. A. as well as a member of its Girl Reserve Committee. Several years ago, she assisted in organizing the Minneapolis Parent-Teacher Association in the program for high school girls. Representing health interests, Mrs. Wahlquist is also a member of the Volunteer Service Bureau of Hennepin County.

Auxiliary Leaders Compile EnviaBle Record

MRS. BAUM'S service as President is the culmination of a long experience in local and state Auxiliary affairs and numerous community organization activities. She has served as President and also as Treasurer of the Marion-Polk County Auxiliary. She has been active in organizational and committee work in the State Auxiliary for many years and has held the office of Treasurer.



MRS. W. WELLS BAUM
Salem
President, Woman's Auxiliary

Mrs. Baum has also given generously of her time and talents to community activities. She is a Past-President of the Salem branch of the American Association of University Women and has served as Chairman of the Salem District of the Girl Scouts of America and as a member of the Board of Directors of the Salem Y. W. C. A.

Mrs. Baum has also done much volunteer work for the Marion County Tuberculosis and Health Association and the Marion County Health Department. During World War II she also served as a volunteer worker in the Blood Donors' Service of the Marion County Chapter of the American Red Cross.

MRS. DOUGLAS, who assumes the office of President in May, 1952, is admirably prepared for this top office.

She is a graduate of the Good Samaritan Hospital School of Nursing and was a member of the second class in public health nursing graduated at the University of Oregon Medical School. As a member of the public health nursing staff of the Oregon State Board of Health, Mrs. Douglas did pioneer work in this field in several Oregon counties.



MRS. VERNON A. DOUGLAS
Portland
President-Elect, Woman's
Auxiliary

She was active in the organization of the Marion-Polk County Auxiliary and served as its Vice-President. Mrs. Douglas was also an ardent worker and held several offices in various parent-teacher associations. She was also instrumental in establishing an art center and choral club in Salem.

Since moving to Portland in 1943, Mrs. Douglas has been an active participant in the work of the Multnomah County Auxiliary. Last year, she served as First Vice-President of the State Auxiliary.

WOMAN'S AUXILIARY PROGRAM

Wednesday, October 10

Tea Hours: 3:00 to 5:00—Home of Mrs. D. C. Burkes
700 N.W. Rapidan Terrace

Hostesses: Woman's Auxiliary to the
Multnomah County Medical Society

Thursday, October 11

Hotel Multnomah

- 9:00 Registration.....Mezzanine Floor
9:30 Meeting of the Executive Board.....Studio Room
10:30 Opening Session.....Colonial Room
Mrs. W. Wells Baum, Salem, Pres., Presiding
Invocation
The Rev. Lansing E. Kempton, Portland
Rector, Trinity Episcopal Church
Pledge of Loyalty
Mrs. James M. Odell, The Dalles
Past-President
Greeting
The Honorable Dorothy McCullough Lee
Mayor of Portland
Welcome
Mrs. Russel L. Baker, Portland
President, Woman's Auxiliary to the
Multnomah County Medical Society
Response
Mrs. Burton A. Myers, Salem, Past-President
Presentation of Convention Chairman
Mrs. Harry B. Moore, Portland
Presentation of Executive Board
Mrs. W. Wells Baum, Salem
Roll Call
Mrs. Harold E. Davis, Portland
Recording Secretary
Reading of Minutes of 1950 Fall Session
Mrs. Davis
Report of Delegates to the National Auxiliary
Mrs. John G. Manning, McMinnville
Mrs. James E. Buckley, Portland
Mrs. W. Wells Baum, Salem
Mrs. Vernon A. Douglas, Portland
Presentation of 1951-1952 Budget
Mrs. Leon A. Goldsmith, Portland
Immediate Past-President
Revision—Footnote to Constitution
Mrs. Edward A. Pierce, Portland
Revisions Chairman
12:30 Luncheon.....Junior Ballroom
Guests of Honor:
Mrs. Harold F. Wahlquist, Minneapolis, Minn.
President, National Auxiliary
Mrs. Herbert W. E. Johnson, Everett, Wash.
Third Vice-President, National Auxiliary

Mrs. E. Arthur Underwood, Vancouver, Wash.
Director, National Auxiliary
Dr. John W. Cline, San Francisco, Calif.
President, American Medical Association
Dr. William J. Weese, Ontario
President, Oregon State Medical Society
Dr. Blair Holcomb, President-Elect
Oregon State Medical Society
Advisory Committee of the Oregon State
Medical Society
Dr. Burton A. Myers, Chairman
Dr. James E. Buckley
Dr. Edwin G. Kirby

Address

Dr. John W. Cline
President, American Medical Association

Hostesses: Woman's Auxiliary to the
Yamhill County Medical Society

- 2:00 Round Table Discussion.....Colonial Room
"Program and Activities of County Auxiliaries"
Mrs. Henry Garnjobst, Corvallis
Program Chairman State Auxiliary
Presiding
Discussion Leaders
Chairmen of Standing Committees
Discussion by Delegates
Summary by Mrs. Garnjobst
6:30 No-Host Dinner.....University Club
Guests of Honor: Women Physicians

Friday, October 12

- 9:00 Past-Presidents Breakfast.....Blue Room
All wives of physicians are cordially invited
Hostesses: Woman's Auxiliary to the
Clackamas County Medical Society
10:30 General Session Colonial Room
"The National Auxiliary"
Speakers:
Mrs. Harold F. Wahlquist
Mrs. Herbert W. E. Johnson
Mrs. E. Arthur Underwood
Questions and Informal Discussion Invited
Resolutions
Mrs. Edward A. Pierce, Portland
Resolutions Chairman
12:30 Luncheon and Fashion Show.....Rose Bowl
2:00 Golf Tournament
6:00 Cocktail Hour with
Medical Society Grand Ballroom
7:00 Annual Banquet with
Medical Society Grand Ballroom
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WASHINGTON STATE MEDICAL ASSOCIATION



ANNUAL MEETING SEATTLE, SEPT. 9-12, 1951

President, K. L. Partlaw, M.D., Olympia

Secretary, J. W. Haviland, M.D., Seattle

Executive Secretary, Mr. R. W. Neill, Seattle

Medical Notes

DRUG EFFECTIVE FOR WHOOPING COUGH. A clinical study by four Seattle physicians has shown that whooping cough can be treated effectively with terramycin.

They treated 21 children aged 3 months to 7 years and noted clinical improvement in 18. Their report appeared in *The American Journal of Medical Science*.

A study by physicians at the Charles V. Chapin Hospital in Providence, R. I., brought similar conclusions.

The Seattle patients were treated at Harborview Hospital by J. C. Michel, F. C. Moll, W. M. M. Kirby and R. J. Sayer.

Personal

TWO PHYSICIANS JOIN CLINIC'S STAFF. Recent additions to the staff of the Doctors' Clinic, Bremerton, are Frederick E. Drew and Michael P. Sperl, Jr., both of whom will engage in general practice. Dr. Drew obtained his medical degree from the Louisiana State University School of Medicine, New Orleans, in 1948 and Dr. Sperl was graduated from the University of Minnesota Medical School and has recently completed his internship at the King County Hospital in Seattle.

E. R. NORTHRUP RETURNS FROM EAST. E. R. Northrup has returned to Spokane after attending a class reunion at Hahnemann Hospital in Philadelphia. He was graduated in 1898. Three members of his class attended the reunion.

FLOTHOW TO ADDRESS PAN PACIFIC SURGICAL ASSOCIATION. Paul Flothow of Seattle has been invited to address a meeting of the Pan Pacific Surgical Association at the Royal Hawaiian Hotel, Honolulu, Nov. 7-19. His subject will be Surgical Treatment of Angina Pectoris, Cardiac Decompensation and Coronary Disease. Dr. Flothow reports that his recent enforced vacation has given him excellent opportunity to prepare the paper.

DIEFENDORF HEADS BUREAU. Richard O. Diefendorf, Bremerton, became president of the board of Kitsap County Medical Service Bureau at the annual meeting held in June. Forty-two physicians of the county attended the dinner session. Ralph L. Smith, Port Orchard, succeeds Diefendorf as vice-president. C. E. Benson and H. A. Barner were elected to the board. Barner, as junior member of the board, became secretary-treasurer. It was reported that average membership in the bureau for the year up to June 1 was 19,161, estimated to be 24 per cent of the county's total population.

J. D. ENTERLINE TO STUDY AT MAYO FOUNDATION. J. D. Enterline is leaving Spokane to accept a three-year fellowship in neurology at the Mayo Foundation, Rochester, Minn. His practice will be taken over by E. B. Saxon, who is a graduate of Harvard Medical School, 1943, and has just completed a residency in general practice at Sonoma County Hospital at Santa Rosa, Calif.

C. R. MCKINLEY OF BREWSTER HONORED. C. R. McKinley, life member of the Washington State Medical Association, Brewster, Wash., was honored on the occasion of his 79th birthday by a party given for him August 7 at the Riviera Club across the Columbia River at Brewster. Forty-two persons gathered at the party to give best wishes to Dr. McKinley, pioneer physician of the area. H. B. Stout acted as master of ceremonies.

In addition to the members of the local Society and their wives, the out-of-town guests included A. G. Young, trustee of the State Association, and wife; Mr. Howard Barnes, Seattle, public relations director of the State Association, and wife; Mr. John Steen, manager of the Washington State Medical Bureau; Mr. Harold Brown, manager of the Chelan County Medical Bureau, and wife.

Dr. McKinley was presented with a large decorated birthday cake bearing candles representing the figure "79" and stating "Happy Birthday, Doc."

"Doc" and his horse, "Buck," were well-known to the early settlers of the Okanogan country about the turn of the century as he helped to write the history of this pioneer area. U. A. Fries in his book "Copenhagen to Okanogan," tells many stories of "Doc" and the difficulties of pioneer medical practice without hospital facilities or laboratory services. He truly lived in the spirit of the frontier physician and was one of those unsung men to whom the profession can look with pride in the knowledge that he helped in the development of the traditions of the profession in the giving of service to his people.

The pioneer physician is nearly gone from the ranks of the doctors. Few of them remain. They wrote a wonderful chapter in American medicine that has been a bulwark to the modern doctor in the understanding and recognition by the public of the value of the physician to his community. The few remaining men of this group hold the respect of their successors for a hard job well done.

Following the party for Dr. McKinley, the society held a business session and the wives toured the Brewster Hospital and inspected the new offices of Drs. Stout and Lamberton in Brewster.

Hospital News

DEACONESS PRESIDENT LAUDS EIGHT OUTGOING INTERNS. Eight outgoing interns were commended for their work in the past year by David Gaiser, president of the Deaconess Hospital medical staff, Spokane, at the group's June meeting.

More than a hundred staff members took part in the session at which papers were presented by Ralph Gustin, Franz Siemsen and Philip Hastings. A seven-doctor panel discussion followed.

HOSPITAL STAFF ADDS SIX INTERNS. Six interns were welcomed to the staff of Sacred Heart Hospital, Spokane, at a banquet held July 1. All committee chairmen, the executive committee and staff officers were present. The interns are J. C. Forsyth, Indianapolis, Ind.; D. T. Molloy and R. M. Wiprud, Omaha, Neb.; G. A. Windle, C. W. Watkins and J. J. Kane, all of St. Louis, Mo.

STATE LEASES YAKIMA HOSPITAL. The state has signed a two-year lease to take over facilities of the Yakima County Hospital to care for 180 mentally deficient children, Gov. Arthur B. Langlie announced July 12 in Olympia. The state contracted to pay \$1,000 a month with an option to buy the hospital during the two-year period and apply the rent on the purchase price. Governor Langlie said the hospital will be operated as a branch of the Rainier school at Buckley under the supervision of T. M. Barber.

PAUL NEWKIRK HEAD OF NEW UNIT AT NORTHERN HOSPITAL. Paul R. Newkirk, associated with the Northern State Hospital staff near Sedro Woolley for the past 11 years, has been named head of a newly created department, Charles H. Jones, superintendent, announces.

Dr. Newkirk will serve as supervisor of diagnostic services to take care of an increased load of psychopathic delinquent cases under the new state law which makes it mandatory to commit such cases to a state hospital for a 90-day observation period.

NURSE SHORTAGE FELT BY ILWACO HOSPITAL. Shortage of nurses, long a problem in hospitals, has become acute at the Ocean Beach Hospital, Ilwaco, according to Mr. Charles F. Boyns, consultant for the hospital district.

Seriousness of inadequate nursing personnel was brought to public attention recently when the hospital cared for a near-capacity number of patients. Hospital commissioners are making every effort to meet the critical shortage and have called upon civic groups to stimulate interest in obtaining nurses. The Ocean Beach Hospital recently was registered with the American Medical Association and approved by the American College of Surgeons.

NEW NAME FOR MARINE HOSPITAL. Name of the Marine Hospital in Seattle has been changed to United States Public Health Service Hospital, in line with similar changes at such hospitals throughout the nation.

The order was effective July 1. Leonard A. Scheele, surgeon-general of the Public Health Service, said the term "Marine Hospital" was no longer descriptive of 21 service hospitals throughout the country. Congress has opened them to many groups besides merchant seamen, for whom they were founded.

Obituaries

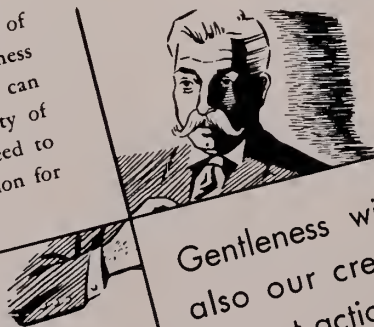
DR. JOHN H. O'SHEA, 68, Spokane, died July 18, and the community and nation at large lost one of its outstanding disciples of organized medicine and free enterprise. Cause of death was mesenteric thrombosis and arteriosclerosis.

Dr. O'Shea came to Spokane in 1907 after his graduation from Harvard Medical School and internship at Boston City Hospital. In 1914 he was elected to the presidency of the Spokane County Medical Society and the following year became a member of the Board of Trustees of Washington State Medical Association, where he served continuously for 34 years. He became president of the state association in 1922. He served as a member of the House of Delegates of the American Medical Association for nearly twenty-five years and was a member of the Judicial Council of the A.M.A. from 1937 to 1949, when he retired from active practice.

During World War I Dr. O'Shea served as chairman of the Medical Advisory Board No. 18 and during World War II he was a member of National Central Committee for the procurement and assignment of physicians and dentists.

Dr. O'Shea was a member of numerous professional

DANIEL DEFOE (1661-1731) gave this bit of wise advice: "Try all methods of gentleness and patience which a forbearing temper can dictate or which prudence and the safety of his debt will allow, before you proceed to prosecution. Proceed with all due caution for the reputation of the debtor."



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societies, including the American College of Surgeons, the founders group of the American Board of Surgery, Spokane Surgical Society, North Pacific Surgical Society, American Association for Surgery of Trauma, and was one of the original incorporators of the Spokane County Blood Bank. Aside from the considerable amount of time spent in these various organizations in the interest of the profession, he found time to devote to many civic and fraternal organizations.

Few men have enjoyed such a wide acquaintance of medical and business leaders throughout the nation. His zealous interest in his profession and fellow practitioners extended from the least to the most prominent. Many of the younger physicians received wise counsel and an ever-helping hand as a result of his generosity and dedication to the fundamental ethics of the medical profession. Few men are so willing to sacrifice their personal time and efforts in the interest of their fellow practitioners.

With the passing of Dr. O'Shea, we must again give tribute to that dwindling group of elder medical

statesmen and realize that the present generation of physicians must continue to dedicate itself to the further improvement and progress of medicine so ably begun by our pioneering predecessors.

WILLIAM H. TOUSEY

DR. BENJAMIN S. CERSWELL, 77, Yakima, Wash., died June 23 of coronary insufficiency, arteriosclerosis, carcinoma of prostate with metastasis, diabetes mellitus. Born in Canada, Dr. Cerswell came to Washington in 1908. He received his medical degree from University of Toronto Faculty of Medicine in 1907.

DR. JACK G. BRADFORD, 30, Montesano, Wash., died July 21. Death was self-inflicted. He was graduated from Northwestern University Medical School, Chicago, in 1947 and was a navy veteran of World War II. Shortly after the war, Dr. Bradford was chief medical officer at the Spokane naval supply depot for two years.

Convention Notes

The 62nd Convention of the Washington State Medical Association had the broadest appeal to members in the history of the Association.

The scientific program, including exhibits, made up a postgraduate course that attracted in generous numbers members from all phases of the practice of medicine. Technical exhibits were an important addition to that program.

Jackie Souders of Seattle and his nine-piece band provided the latest terpsichorean scores for the Tuesday night dance in the Olympic Bowl, Olympic Hotel, and the Annual Banquet, on the same night, was one of the brilliant affairs of the fall social season.

Breaking a precedent for the State Convention, President Partlow ordered a reception for the incoming president, R. A. Benson of Bremerton, to close the Convention. This affair was held in the Junior Ball-

room on Wednesday evening. Refreshments were served.

Dr. Partlow delivered his presidential message at 11:30 a. m. on Tuesday and Editor John McClland, Jr., of Longview, preceded him with a paper bearing on press relations.

Leone Baxter and Clem Whitaker, A.M.A.'s hard-working public relations team, held the spotlight at the Public Relations Luncheon on Wednesday noon. This program was open to Auxiliary members as well as physicians, and the State Medical Association was host at the luncheon.

The House of Delegates met in final session on Wednesday afternoon, when the incoming president was installed and new officers of the Association were elected.



HAROLD G. WOLFF



MRS. H. F. WAHLQUIST

Featured speaker on the Washington State Medical Association Convention program, on Tuesday afternoon, Sept. 11, was Dr. Harold G. Wolff, Professor of Medicine (Neurology), Cornell University Medical College. Subject of his paper was "Practical Aspects of Treatment of Headache." Dr. Wolff obtained his B.S. Degree at the College of the City of New York and his M.D. and M.A.

degrees at Harvard University. He is author of several major publications.

Above, right: Mrs. Harold F. Wahlquist, Minneapolis. President, Woman's Auxiliary to the American Medical Association, who addressed the delegates at the Tuesday and Wednesday meetings and installed new state officers Wednesday morning.

State Department of Health

In view of the growing incidence of malaria among returning Korean war veterans, J. A. Kahl, acting State Director of Health, warns all practicing physicians in Washington to be on the lookout for the disease in order to initiate prompt treatment with modern antimalarials.

While past experience in Washington would indicate that the chances of malaria spreading from these returning servicemen is slight in this state, Dr. Kahl advised continued vigilance to keep the state free from endemic malaria, and asked that local health departments be notified when cases are found. He noted that the disease is endemic in the Willamette Valley in Oregon.

Malaria is spread by anopheline mosquitoes. Surveys have shown that anophelines exist generally in Washington, but not in numbers sufficient to make them a significant vector of malaria. These mosquitoes were found to be most numerous in the Yakima Valley, but sprays used to protect fruit and other crops have had the secondary effect of keeping the mosquitoes under control.

Historically, 26 cases of malaria of presumably native origin have been recorded in Washington since 1928. No native cases have been reported since 1946, although there had been apprehension that returning World War II veterans might establish a reservoir for the spread of the disease.

Quoting a Public Health Service report, Dr. Kahl said significant numbers of military personnel returning from Korea are experiencing attacks of vivax malaria while on leave or after separation from the service. Some of these individuals will undoubtedly be found in Washington, he stated.

The returnees having malaria probably acquired the infections last fall, though in some instances it is probable that symptoms were not manifested until this spring due to prolonged incubation or the effects of suppressive medication.

Malaria should be suspected among patients presenting suggestive signs and symptoms and who have been in Korea during the last year, Dr. Kahl said. Definitive diagnosis should be based on a laboratory demonstration of malaria parasites. Blood smears may be sent to the State Health Department laboratory for this purpose. The chances of discovering parasites are much better in thick blood films than in thin ones. To make a thick blood film preparation, a large drop of blood is placed on one end of a glass slide and stirred immediately with the corner of another slide until the blood is evenly spaced over an area about 1 cm. in diameter. The smear should be allowed to dry. Where blood findings are positive, controversial or uncertain, the State Health Department will send the slides to the National Depository for Malaria Slides, Communicable Disease Center, Chamblee, Georgia, for further examination.

Treatment with modern antimalarials now available (chloroquine, pentaquine, chlorguanide, etc.*) will alleviate symptoms promptly. Certain of the cases receiving complete courses of these drugs will remain

free from malaria, but it is probable that others will relapse after weeks or months. The likelihood of clinical reactivation becomes less with the passage of time; relapses are rare after the second or third attack.

*Cooper, W. Clark: Summary of Antimalarial Drugs. Public Health Reports, Vol. 64, No. 23, pp. 717-732. June 10, 1949.

Poliomyelitis and Immunizations

At the Sixth International Congress of Pediatrics held in Zurich in 1950, two reports were made, one from London, the other from Australia, presenting information which suggested an association between receipt of inoculations for immunization and the development of paralytic poliomyelitis in the same extremity.

Since that time there have appeared in the press and various science publications many comments, cautioning of a potential risk in administering such inoculations during periods when polio is prevalent in a community. Particular reference may be made to an editorial in *J. A. M. A.*, Vol. 144, No. 3, September 15, 1950, and in the same issue, a review of the evidence by Dr. Leake, found in the "Correspondence" section (p. 259). Other articles discussing the available information may be found in the *Canadian Journal of Public Health*, Vol. 41, November, 1950, another letter in the "Correspondence" section of *J. A. M. A.* of February 17, 1951 (Vol. 145, No. 7) and a statement by the Committee on Research and Standards of the American Public Health Association, appearing in the June, 1951, issue of the *American Journal of Public Health*.

Our interpretation of the information presented may be summarized as follows:

1. There appears to be definite evidence of association of parenteral injections into extremities and development of paralytic polio in the same extremity if the injection has been administered within a month of the date of onset of the illness. That is to say, if a person who has received a parenteral injection develops polio within a month after the injection, there is a definite tendency for the paralysis to involve the limb into which the injection was made. Such parenteral injections include not only those given for im-

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munizations, but also any other type, such as liver extract, antibiotics, etc.

2. There is still considerable debate regarding the proposition that such parenteral injections actually predispose patients to development of paralytic poliomyelitis. An extensive study conducted in New York state last year (1950) is suggestive of this indication, but needs to be repeated and studied further. The following is a summarization of their study and conclusions: Information was obtained concerning all injections received by the 2,137 cases of polio reported in that state last year. This information included data on all injections received during the two-month period preceding onset of each case, such as the type of material injected and date given. Identical information was obtained from each member of the household of the patient (6,055 persons), and from the members of three additional families living on either side and across the street from the patient (14,710 persons). The investigators reported the following findings (quoted from a summarization issued by the New York State Health Department, June 2, 1951):

"A history of an injection during the month before onset was twice as frequent among poliomyelitis patients as among either the household or extra-household controls at every age level. This ratio was about the same for injections of immunizing materials, as for penicillin alone, and a miscellaneous group of other injections including hormones, liver extract, and local anesthetics. Injections of penicillin given during the week before onset were excluded from the analysis.

"By calculating the poliomyelitis attack rate per 1000 injected persons and comparing it with the attack rate per 1000 non-injected persons, the analysis disclosed that the risk of getting paralytic poliomyelitis at each age group is doubled in the injected population.

"In addition, the study shows a clear-cut association between site of injection and site of paralysis. For example, of the paralytic poliomyelitis patients without history of recent injections only 34 per cent had arm involvement; of patients with arm injections during the period 8-14 days before onset, 77 per cent had

arm paralysis. Of the group with arm injections 15-21 days before onset, 62 per cent had arm paralysis; and of those injected 22-28 days before onset, 50 per cent had arm involvement."

Comment: In regard to the New York Study, further investigation might implicate the condition underlying the necessity for certain parenteral injections, as predisposing to the development of polio, rather than the injection itself (although the site of injection may furnish at least one area of localization).

In regard to a policy to follow in administering injections of immunizing agents during the polio season, it is our feeling that the recommendation issued by the Committee on Research and Standards of the American Public Health Association is reasonable and sound. This recommendation was published in the June, 1951, issue of the *American Journal of Public Health* as follows:

"Recent published and unpublished data strongly suggest that an individual who develops poliomyelitis within a month after receipt of an injection of an antigen, or possibly of some other material, shows an increased frequency of paralysis in the extremity into which the injection has been given . . . the data so far available would suggest that, in the fact of an *abnormal prevalence* of poliomyelitis in a given locality, antigen inoculations may well be postponed until after the subsidence of the abnormal prevalence."

In this state, the incidence of polio is usually lowest during March and April, the seasonal increase beginning in May or June.

In communities experiencing an incidence of polio above the endemic level (approximately, above 15 cases per 100,000 population), it will be advisable to postpone immunizing children (except infants under six months of age) until the early spring months indicated. It should be reasonably safe to immunize children during the fall months in those communities in which polio has not had an incidence above the usual endemic level.

W. R. GIEDT, *Epidemiologist*
Washington State Department of Health

Spotlight on Service

Arranges Symposia on Arteriosclerosis

William E. Watts of Seattle is arranging for teams of physicians to visit various county societies throughout Washington this fall to talk on arteriosclerosis. He is chairman of the committee on county symposia for the Washington State Heart Association.

Attesting to the success of last spring's series on rheumatic fever in which 14 societies were addressed by a three-man team, seven counties have already requested speakers on the new subject. They include: Clallam, Skagit, Kittitas, Pacific, Snohomish, Pierce and Whitman.

These county symposia are one of the focal points of the Heart Association's campaign of professional education.

Hartley New President of Health Council

Herbert Hartley was recently installed as the new president of the Health Division, Seattle Health and Welfare Council. He succeeded Robert Rutherford,

who has served for two years as president. M. Shelby Jared was the first president.

The Health Division is the community health council for Seattle and King County. It consists of representatives of about forty lay, voluntary and professional groups in the health field. It has played a key role in coordinating health efforts since its organization in 1946. One of its major projects in the past year was completion of a 120-page evaluation of public health services in the city and county, representing many months of conscientious effort on the part of professional and lay persons alike, all volunteering time and talent for an important community service project.

A number of physicians are serving on a newly-organized committee of the Council to explore possibilities for an outpatient psychiatric clinic for adults. They include Douglas Orr, Herbert Ripley, J. B. Spielholz, Donald Thorp and Hartley.

Physician members of a study committee on alcoholism include Philip M. Frederick, Richard E. Roys,



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Frederick Lemere, Charles D. Rehm, L. E. Powers and S. P. Lehman. Powers and Lehman are also on the Executive Committee.

Other physicians participating are Mildred Mumby, social hygiene committee; K. K. Sherwood and Ralph M. Stolzheise, care of the aging. Stolzheise also serves on the alcoholism committee.

Plan Fall Meeting on Vascular Disease

Under direction of Kazimir B. Skubi, chairman of the State Heart Association's committee on professional education, six physicians are arranging for a symposium on certain heart conditions at the University of Washington, October 19 and 20.

Serving on the committee are Robert F. Foster, C. E. Watts, L. A. Dewey, Robert A. Bruce and Averly M. Nelson of Seattle and Sidney T. Scudder of Bellevue.

Subject of the symposium will be peripheral vascular disease and congestive heart failure. Speakers already secured include Travis Winsor of Los Angeles, Norman E. Freeman of San Francisco and Robert P. Glover and Henry Janton of Philadelphia.

Civil Defense Active in Grays Harbor

Grays Harbor County is making excellent progress in its civil defense medical services setup. Its participating roster includes 42 physicians, 22 dentists, more than a hundred graduate nurses, 6 x-ray technicians, 9 laboratory technicians, 29 pharmacists and 4 funeral directors. More than 1,000 persons have volunteered for civil-defense jobs to date.

Five local doctors attended the Institute on Radiological Warfare at the university last fall and a meeting of the society was devoted to their report.

Since then long strides have been made in the area toward medical mobilization for disaster services. Milton P. Graham is chairman of the society's civil defense committee, while James E. Galbraith, health officer, is the over-all coordinator of medical services.

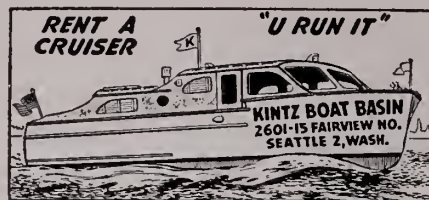
Ten first-aid stations have been set up to service Aberdeen, Hoquiam and Cosmopolis. Each has physicians, dentists, nurses and pharmacists. In addition, there are aid stations in Elma, Montesano and McCleary.

First-aid team captains include William H. Hardy, F. T. O'Brien, E. Z. Jones, A. W. Riedesel, C. T. Smith, Arthur M. Skarperud, R. F. Ballard, W. L. Curtis, Leonard Semler and John D. Ehrhart. In addition, 33 physicians are members of emergency surgical traveling teams, available for aid to stricken areas.

Through efforts of the local medical society, three hospitals are now cooperating with the Portland Red Cross in collecting blood for Korea. Lists of donors are available for civil-defense emergency.

* * *

The foregoing are a few news notes on some typical activities, representing not all, but a cross-section of the public service constantly being rendered by physicians. The Washington State Health Council, 905 Second Avenue Building, Seattle, prepares these notes for NORTHWEST MEDICINE and welcomes any contributions on activities in your area.



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IDAHO STATE MEDICAL ASSOCIATION



SIXTIETH ANNUAL MEETING
JUNE 16-18, 1952
SUN VALLEY

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Secretary, R. S. McKean, M.D., Boise

Exec. Secy., Mr. A. L. Bird, 305 Sun Bldg., Boise

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E. Victor Simison, M.D., Pocatello

Address of Alfred M. Popma, Boise, President, Idaho State Medical Association Delivered at the Annual Banquet of the Association, Sun Valley, June 20, 1951

President Scott, Members of the Council, House of Delegates and the Idaho State Medical Association:

It is indeed an esteemed honor and privilege to be presented to you this evening as your incoming president. The trust of leadership which you impose upon your elected officers and councilors is by no means small. I feel that it is impossible to be entirely and completely cognizant of all of the responsibilities and duties which fall upon the shoulders of your president and other officers.

It will be extremely difficult to aspire to and attain the standards of excellent guidance and leadership manifested by my immediate predecessor, Dr. Scott, and all the other officers who in bygone years have so earnestly and unselfishly given of their time and energies to build and strengthen our organization. It is therefore with humility that I assume this office during this, our 59th annual meeting.

Few states have been so fortunate as ours in securing such widespread cooperation from the membership of the state association. There have frequently been honest differences of opinion, but at no time has there ever arisen a problem of any magnitude which required complete cooperation that such cooperation was not immediately forthcoming. To the members of our association can, therefore, be attributed in a large degree the success of the Idaho State Medical Association. Such continued unanimity, and this alone, will determine a successful program during the coming year.

The passing of the years has brought the medical profession more and more into the limelight of public scrutiny. Much of this has not been of our own choosing, but rather we have been forcibly brought before the eye of the public through the efforts of individuals and groups, some of whom are trying to degrade and enslave the physician, while others are seeking to elevate, enrich and extend the profession.

We have therefore a serious problem of public relations which has been thrust upon us and with

which we are faced.

This is a problem which is not insoluble, but rather can be readily attended to by the combined efforts of the physicians. The best and most effective public relations work is that which is done by each individual each of the 365 days of a year. At the same time it would be well to remember that the thoughtless word or act on the part of only one individual can undo, in a few moments, all the good work previously done by the combined efforts of an entire community of physicians.

The Idaho State Medical Association is comprised of ten component society organizations. These district groups form the backbone and provide the working manpower for the functions of the state organization. To that end it will be our aim during the coming year to further and improve the already existing good relationships between the various societies.

It will be our plea to maintain our state association as a group of doctors united in a common cause, rather than a loosely knit association of special groups. It is the feeling of your officers and councilors that all special interests should be merged and that the state association continue to remain THE organization, OF, BY, and FOR the physicians. Only in this manner can effective action be maintained against those who seek to disrupt and destroy us.

As physicians, having special knowledge and skills, we are confronted with several immediate and pressing obligations. The formation and construction of a civil defense program is urgent. A well-devised plan



A. M. POPMA

will be presented by your committee for this purpose. The plan will be integrated to fulfill the needs of each community in close cooperation with the state department of Civilian Defense.

The perennial problem-child, prepaid medical care, is still with us. Your committee has made excellent progress through many days of long, tedious work and I am confident that with the next year there will be forthcoming from this committee an adequate plan which will be satisfactory to the profession at large, and will provide care for that class of people who are not now receiving proper and adequate attention.

Medical education has never before been considered a problem in our state. In past years Idaho students seldom encountered any difficulty in seeking admission to medical schools. Today the situation has changed markedly. With the enormous increase in the number of applicants for medical training, tax-supported schools in other states are reluctant to accept non-residents in deference to their own resident students. We in Idaho are dependent upon institutions in other states to furnish our people with sufficient medical personnel.

Therefore in order to assure the people of our state continuing medically trained young men and women, and to provide medical educations for such Idaho residents who may wish to become physicians, a

cooperative project should be planned with other interested agencies, particularly the State Board of Education, to study the problem and to attempt to arrive at a satisfactory solution. This is a program which cannot be accomplished in a brief, time but rather will require prolonged careful study and possible legislative action.

Several medical problems have arisen in regard to legislation for the healing arts. As an association we are committed to help formulate a good basic science act for presentation to the next legislature. This, along with the continually recurring problem of broadening privileges of other groups, will occupy a great amount of time and energy of your legislative committee during the coming year. This committee, as well as all other committees, will welcome, I am sure, any suggestions and help to assist them in their work.

In conclusion, I would like to thank you for this honor which you have bestowed upon me. Please accept my assurance that I shall do everything within my powers to serve you well. I know I speak for all the officers and councilors when I say that our sole purpose is to improve our association so that it may serve you better in your everyday practice which eventually means better medical care for our patients. To accomplish this end I ask, and know that I shall receive, assistance and help from each and everyone of you.

Medical Notes

IDAHO HEART ASSOCIATION PICKS OFFICERS. George E. Brown, Jr., Twin Falls, has taken over duties as president of the Idaho Heart Association for the coming year. Burton Stein, Lewiston, president-elect, named at the two-day meeting of the group in Boise on June 1 and 2, will become president at the next annual meeting of the association.

Other officers elected were Richard Howard, Pocatello; O. F. Swindell, Boise, and Harvey Hatch, Idaho Falls, regional vice-president; Glenn Voyles, Twin Falls, secretary, and Mr. William Goodall, Boise, treasurer.

Approximately 60 doctors from Idaho and Eastern Oregon attended the two-day meeting, Paul F. Miner, Boise, arrangements committee member, said. Speakers included Hans H. Hecht, Salt Lake City; Robert A. Bruce, Seattle; Herbert E. Griswold, Jr., Portland, and William W. Hurst, Great Falls, Mont.

Personal

J. B. Marcusen, who has been Kuna's physician for the past year, left recently for Randolph Field Air Force Base in Texas for two years' active duty. He had previously served with the U. S. Medical Department and has been in the inactive service. While he is away, A. B. Halliday of Nampa will receive and treat patients at the Kuna office.

Charles R. Blackburn, former hematologist and staff physician with the Cushing Veterans Administration Hospital in Massachusetts, has opened a medical practice in Boise and will be associated with Roy C. Crosby. Dr. Blackburn will engage in the practice of internal medicine and specialize in hematology.

Alfred H. Rossomando, urologist, has located in Boise. He comes to Idaho from New York City where he was associated with the New York Medical College and the Fifth Avenue Hospital.

Obituaries

DR. JOHN BOECK, 89, a Boise physician for 50 years, died June 25 at his home after a prolonged illness precipitated by a fall about a year ago. He came to Boise in 1901 where he maintained his practice until he was 85 years old. Dr. Boeck was a member of the Southwestern Idaho Medical Society and the American Medical Association.

DR. RUSSELL TIGERT, 64, Soda Springs, died June 26 as the result of injuries sustained in an automobile accident the day previous. Dr. Tigert received his medical degree from College of Physicians and Surgeons, Memphis, Tenn., in 1910 and had resided in Soda Springs 36 years, where he was active in civic, school and fraternal affairs.

DR. ALBERT J. COATS, 76, Boise physician, drowned in Henry's Lake July 1 when his boat overturned. Dr. Coats came to Boise in 1926. He received his medical degree from Northwestern University Medical School, Chicago. He was a member of the Southwestern Idaho Medical Society, the Idaho State Medical Association and the American Medical Association.

DR. RICHARD J. SUTTON, 68, Oakley, died June 3 of arteriosclerotic heart disease. Dr. Sutton came to Idaho in 1913, the same year he received his medical degree from the Chicago College of Medicine and Surgery.

ALASKA TERRITORIAL MEDICAL ASSOCIATION

President, H. Romig, M.D., Anchorage



ANNUAL MEETING Anchorage, June, 1952

Secretary, W. P. Blanton, M.D., Juneau

Medical Notes

Outstanding results achieved by use of streptomycin in treatment of bone tuberculosis at Mt. Edgecumbe Medical Center were reported by Philip Moore at the June 20 meeting of the American Orthopedic Association in White Springs, W. Va.

"At least three amazing results were produced by the use of streptomycin," said Dr. Moore, orthopedic surgeon at the island hospital where streptomycin treatment was begun two years ago. "Most important, the use of streptomycin definitely saved the lives of some patients. Furthermore, we established the fact that use of streptomycin effected arrest of tuberculosis of bones and joints in all patients treated and its use definitely reduced the hospitalization period needed to arrest the disease."

Since use of the drug was begun at the Orthopedic Unit in April, 1949, 100 patients have received streptomycin treatments, according to Moore. Work with the new drug was made possible at Mt. Edgecumbe through a National Research Council grant.

As a specific example of the drug's effectiveness, Moore mentioned the case of a three-year-old child who arrived at the Orthopedic Hospital with draining lesions from tuberculosis of both elbows and knees.

"The disease was far advanced," Moore explained. "It appeared even surgery would leave him with stiffened joints. He needed to be built up physically with good food and rest and, while this was being done, we began the administration of streptomycin. Today, that little fellow is running and playing ball, with every indication that complete use of his limbs is being restored and that the disease can be arrested in him. No surgery has been done or will need to be done."

Moore also presented a paper before the Society for Traumatic and Orthopedic Surgery at Columbus, South Carolina.

Personal

L. P. Dawes, former Juneau physician now retired, is confined to St. Ann's Hospital in Juneau with a cardiac condition. Dr. Dawes, one of the pioneer physicians in the Territory, was honored two years ago

by being awarded the General Practitioner award by the Alaska Territorial Medical Association.

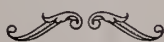
Milton O. Kepler, formerly of Fort Yukon, Alaska, is now practicing at Skagway in Southeast Alaska.

New medical director and general practitioner at the Seldovia General Hospital is Robert A. Dexter, who is a graduate of the College of Medical Evangelists, Loma Linda, Los Angeles, Calif. He is also a registered laboratory technician. Dr. Dexter took his internship at the Portland Sanitarium and Hospital, Portland, Ore., and spent three years with the Army, part of which was overseas duty. He is accompanied to Alaska by his wife, who is a registered nurse. He has been sent to Alaska under sponsorship of the Seventh Day Adventist Church, which will operate and maintain the Seldovia General Hospital and obtain nurses for the facility, in cooperation with the City Council.

Robert Smith, assistant commissioner of health, has been appointed as acting medical director of the Arctic Research Center. He temporarily replaces Jack Haldeman, who has been transferred to Washington, D. C., as medical director, chief division of state grants in the Bureau of State Services. No permanent appointment has been announced as a replacement for Dr. Haldeman.

John Stewart, formerly of Anchorage, is now associated with J. O. Rude and J. H. Clements' Clinic in Juneau.

Joseph D. Aronson, professor of bacteriology at the University of Pennsylvania, arrived in Alaska in June to check the records on tuberculosis patients included in a BCG vaccination study he started in the Territory 14 years ago. Approximately 1,000 cases are included in Dr. Aronson's present project which is sponsored by Phipps Institute and the Alaska Native Service. Dr. Aronson is in charge of the Pennsylvania State BCG laboratory.



Postgraduate Courses

University of Oregon Medical School

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Faculty: University of Oregon Medical School faculty as well as guest speakers of outstanding national reputation, including Dr. Cushman Haagenson, New York; Dr. N. F. Hicken, Salt Lake City, and Russell de Alvarez, Seattle.

October 15-19

General Surgery—Tuition Fee \$50.00

Faculty: John Adams, Allen Boyden, Lester Chauncey, Edward Davis, Arthur Frisch, Louis Gambee, J. A. Gius, P. C. Green, J. A. Laird, Lawrence Lowell, K. H. Martzloff, Matthew McKirdie, H. Minor Nichols, Clare Peterson, M. S. Rosenblatt, Willard Rowland, Werner Zeller.

October 22-26

Gastroenterology—Tuition Fee \$50.00

Faculty: Abraham Aaron, G. A. Boylston, John Fitzgibbon, Arthur Frisch, Louis Gambee, Hance Haney, Clifford Hardwick, Willard Hollenbeck, Milton Hyman, Daniel Labby, H. P. Lewis, Charles Littlehales, Lenier Lodmell, George Long, Frank Perlman, Dean Seabrook, Laurence Selling, B. O. Woods.

October 29-31

Diseases of the Chest—Tuition Fee \$30.00

Faculty: Wm. Conklin, C. Eastlake, S. Farber, A. Frisch, Morton Goodman, H. E. Griswold, Jr., John Higginson, Thomas Holmes, W. Hunter, John Krygier, H. P. Lewis, Lawrence Lowell, G. Maurice, J. Speros, John Tuhy, C. P. Wilson.

Physicians attending this course are invited to participate in the meeting of the Northwest Chapters of the American College of Chest Physicians and American Trudeau Society to be held at the Medical School, November 1 and 2. Guest lecturers for the above course include: Thomas H. Holmes, Assistant Professor of Psychiatry, University of Washington School of Medicine, and Seymour Farber, University of California Medical School.

University of Washington School of Medicine

September 17-19

Recent Advances in Hematology—Tuition Fee, \$25.00

Faculty: J. B. Bingham, clinical instructor in medicine; D. H. Coleman, assistant in medicine; Q. B. DeMarsh, assistant professor of anatomy; R. S. Evans, chief of medicine, Veterans Administration Hospital, Seattle; C. A. Finch, associate professor of medicine; W. A. Ricker, associate professor of pathology; Evans Speer, clinical associate in medicine, and A. R. Stevens, Jr., assistant in medicine.

October 1-3

**Diagnosis and Treatment of Infectious Diseases—
Tuition Fee \$30.00**

Faculty: R. A. Bruce, C. A. Finch, B. F. Francis, R. J. Davies, J. W. Haviland, W. M. M. Kirby, A. S. Lazarus, Ph.D., D. F. McDonald, K. A. Merendino, M. A. Mills, F. C. Moll, S. T. Scudder, W. W. Sims, D. R. Sparkman, W. B. Spickard and Wade Volwiler.

Both of these courses will be held in the Health Sciences Building at the University of Washington.

San Francisco Heart Association

October 24-27, St. Francis Hotel

Oct. 24: Course in Unipolar Electrocardiography. Heart Disease in Childhood. Cardiac Auscultation.

Oct. 25: Medical and Surgical Aspects of Correctible Cardiovascular Lesions.

Oct. 26: Presentation of Selected Cases of Cardiovascular Problems. Arteriosclerosis and its Sequelae.

Oct. 27: Presentation of Patients with Various Types of Heart Disease.

Washington State Heart Association

Washington State Department of Health

**October 19 and 20, University of Washington
Medical School Auditorium**

No Registration Fee

Speakers: Travis Winsor, Los Angeles; Norman E. Freeman, San Francisco; Robert P. Glover and O. Henry Janton, Philadelphia, Pa.

In addition to their scheduled papers, the speakers will conduct panel sessions and discuss questions from the audience. Arrangements will be made for an interpretation of your problem EKG's by Dr. Winsor, co-author of the book, "Primer of Electrocardiography."

Second Annual Alfred A. Strauss Lecture

Friday, October 26, 1951, 8:30 p. m., Health Sciences Auditorium, University of Washington.

Subject: Importance of Pathological and Radiolog-

ical Studies in Diagnosis and Treatment of Cholelithiasis.

Speaker: Dallas B. Phemister, M.D., Dept. of Surgery, University of Chicago.

MISCELLANY

Trustees Appoint Herbert L. Hartley Editor-in-Chief for Northwest Medicine

Highlight of the midyear meeting of the Board of Trustees and staff of *NORTHWEST MEDICINE*, July 29, was appointment of Herbert L. Hartley as Editor-in-Chief



HERBERT L. HARTLEY

of the journal. Clarence A. Smith was made Editor Emeritus.

The Board met at the Olympic Hotel, Seattle, for an all-day session of discussing editorial policy and future plans for the journal in all its departments.

A vigorous plan of expansion and stimulation of interest in the journal is planned by Editor Hartley. This will include wider coverage of the news throughout the three states and Alaska with emphasis on activities of component medical groups and individuals, clinics and research projects, as well as progress and interests of those who serve the medical profession. In line with engaging the participation of component societies in making their journal, *NORTHWEST MEDICINE*, a more active spokesman for them, the editor hopes, as time permits, to personally attend meetings of each group to determine how the journal may be of utmost service.

Another new development discussed at the trustees meeting was withdrawal of *NORTHWEST MEDICINE* from State Journal Advertising Bureau, which was effected July 1. This places *NORTHWEST MEDICINE* in a position to serve more effectively its advertisers, both in the national and local field, since advertising acceptability of products and services is now determined by the advertising committee of *NORTHWEST MEDICINE*. Operating independently of the State Journal Advertising Bureau of the A.M.A., *NORTHWEST MEDICINE* is able to cooperate directly with manufacturers and those other services identified with the medical profession who are eager to reach and explore the rapidly expanding medical field in the Pacific Northwest. In a letter to Mr. Jackson of the State Journal Advertising Bureau, the trustees of *NORTHWEST MEDICINE* gave high praise to the Bureau and its staff which has so ably served *NORTHWEST MEDICINE* since 1914. "Our decision is necessary for purely financial reasons and is in no sense a reflection on the fine work you have done," the letter stated.

Trustees who attended the meeting include Karl H. Martzloff, president, Portland, Ore.; J. V. Straumfjord, Astoria, Ore.; R. W. Esperson, Klamath Falls, Ore.; F. C. Harvey, Spokane, Wash.; L. A. Hopkins, Tacoma, Wash.; Gayton S. Bailey, Seattle, Wash.; W. R. West,

Idaho Falls, Ida., and D. M. Loehr, Moscow, Ida. C. O. Armstrong, Moscow, was unable to be present.

Also attending at the invitation of the Board were Mr. Clyde C. Foley, executive secretary of Oregon State Medical Society; Mr. Armand L. Bird, executive secretary of Idaho State Medical Association, and A. M. Popma, president of the Idaho State Association. Mr. R. W. Neill, executive secretary of the Washington Association, was on vacation. In the course of discussions these guests were asked to give their opinions. Their counsel was found to be most helpful to the trustees and staff.

Northwest Medicine Now On Its Own

Withdrawal of *NORTHWEST MEDICINE* from State Journal Advertising Bureau of American Medical Association, as announced by the Board of Trustees, effective July 1, 1951, means that *NORTHWEST MEDICINE* is now on its own as far as advertising patronage and advertising acceptance is concerned.

Hereafter, all advertising submitted to *NORTHWEST MEDICINE* for publication will be judged by *NORTHWEST MEDICINE* Advertising Committee only, consisting of Herbert L. Hartley, chairman; James W. Haviland, Gayton S. Bailey, Fred A. Ellis and M. Shelby Jared.

Action of the trustees in establishing an independent advertising department to cover both the national and local fields, places *NORTHWEST MEDICINE* among the first five state medical journals of the U. S. A., including *New York State Journal of Medicine*, *California Medicine*, *Southern Medical Journal* and *Illinois Medical Journal*.

Mr. Gordon Marshall, widely known in medical centers of the nation and formerly with the State Journal Advertising Bureau and New York State Journal of Medicine, is manager of the national advertising department of *NORTHWEST MEDICINE* with offices in Seattle, Chicago and New York.

Seventeenth Annual Meeting of the American College of Chest Physicians was held in Atlantic City, N. J., June 7-10, with registration of 1,040. The following officers were elected for the coming year: C. L. Jackson, Philadelphia, Pa., president; A. L. Banyai, Milwaukee, Wis., president-elect; A. E. Greer, Houston, Texas, first vice-president; W. A. Hudson, Detroit, Mich., second vice-president; Minas Joannides, Chicago, Ill., treasurer, and C. K. Petter, Waukegan, Ill., assistant treasurer.

At a convocation ceremony held June 9, 109 physicians received their fellowship certificates. John E. Nelson, Seattle, serves as governor for the college for the State of Washington.

American College of Surgeons

Thirty-seventh annual Clinical Congress will be held in San Francisco, November 5-9, 1951, with headquarters at Fairmont Hotel and Civic Auditorium. Thirtieth annual Hospital Standardization Conference is scheduled to be held concurrently, with meetings in the Civic Auditorium as a part of the Congress. Several thousand surgeons and hospital representatives are expected to attend.

Dr. Emile Holman is chairman of the San Francisco Committee on Arrangements. Hospital conference program is in charge of Dr. Paul S. Ferguson, acting assistant director in charge of hospital standardization.

Pathologists to Hold Joint Meeting

Joint meeting of Pacific Northwest Society of Pathologists and the Northwest Group, College of American Pathologists, will be held in the Department of

Pathology, University of Washington School of Medicine, Friday and Saturday, September 28 and 29.

The meeting will feature an address by E. T. Bell, Professor of Pathology, University of Minnesota Medical School, on glomerular and tubular lesions of the kidneys.

A banquet for attending members will be held at the Washington Athletic Club, Friday evening, September 28.

Portland Academy of Medicine

Meeting of Portland Academy of Medicine will be held at University of Oregon Medical School auditorium, October 23 and 24. Two lectures will be presented by Professor J. Douglas Robertson, Department of Clinical Investigation, London Clinic, London, England. Subjects are: "Normal and Abnormal Basal Metabolism; Therapy of Hypo- and Hyperthyroid States" and "Some Clinical, Pathological and Historical Observations in Simmonds' Disease."

Status of Practical Nurses in Washington

Should physicians, as a means of improving medical and nursing service to the public, encourage recruitment of licensed practical nurses and use them in caring for their patients?

Physicians may disagree in principle, methods and objectives, so NORTHWEST MEDICINE asked Mrs. Ethel S. McMahon, executive secretary of the Practical Nurses Association of Washington State, to point out what she considers the many benefits that accrue from the practical nurse program now developing in the State of Washington and recite a few things the physician can do to encourage wider development of the nursing skills. Says Mrs. McMahon:

"Our nurses are licensed nurses. They pass the state board examination, qualify in health and intelligence and establish an experience and training record for the doctor's perusal.

"Licensed practical nurses do not replace registered nurses. Instead, they supplement the work of the registered nurse, free her for the higher and more technical skills of the profession and provide her with talented help when she needs it."

A joint committee of practical and registered nurses now functions to bring about coordination of nursing activities and education within the state. Registered nurses, according to Mrs. McMahon, agree that there is a place for the licensed practical nurse that is proving a great boon to bedside and medical care.

Washington has approximately 3,000 licensed practical nurses, needs 2,000 more to meet current demands.

Approved nursing courses leading to a state license are opening in Walla Walla, Yakima, Vancouver, Aberdeen, Bellingham, and Wenatchee. Accredited courses are already instituted in Seattle, Spokane and Tacoma under vocational education. Bremerton and

Everett courses are in operation under the Junior College program.

Mrs. McMahon states that other courses are being offered in various price brackets but warns that they may not be accredited, in which case graduates would not be eligible for state license.

If physicians wish to aid recruitment in the field of practical nursing they can use the following argumentative inducements:

Practical nurses receive excellent pay. While the rates of pay vary from city to city it will usually be found that their schedule is about 75 per cent of the rates for graduate nurses.

Aims and purposes of licensed practical nurses are generally quite well understood by registered nurses and the two associations are cooperating extensively in the recruitment program.

Practical nurses are licensed and protected by state laws.

Licensed practical nurses, with two years experience, are qualified under new state statutes, to be supervisors of nursing homes.

Practical nurses are on the visiting nurse program now active in Seattle and Spokane.

Practical nurses are organized in twenty counties of the state.

The association maintains 24-hour placement service in Seattle, Tacoma and Spokane, for the benefit of the licensed practical nurse as well as physicians.

The Practical Nurses Association of Washington State obtained its licensed status in June, 1949, after a 12-year struggle. Since then it has progressed steadily in education, recruitment and organization.

Mrs. Pearl Faunce of Bremerton is state president. Mrs. Alda Palmer manages the King County District Placement Service with offices in the Medical Arts Building, Seattle. Mrs. Edna Richardson and Mrs. Nettie Turnley operate the Spokane District Placement Service Bureau in Spokane.



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Administrator



Correspondence

August 2, 1951

To the Editor:

... regarding your fine new column with the strange title (*Theriaca Andromachi*), what are you trying to do—confuse people? I thought I knew most of the words, but I had to look that one up and I'm still confused. The dictionaries are all rather vague and keep talking about molasses.

I don't get it. What are the seventy ingredients? And *who* are the venomous animals?

Sincerely yours,

F. B. EXNER

This is not the only request for information about the "strange title." Others, also, have looked up the words and found rather unsatisfying definitions of this ancient name. When we selected those very old words to head our column we were thinking of a variety of contents, not confusion of readers, molasses or venomous animals. We sincerely hope it never gets sticky, we are quite sure that it will not be characterized by noticeable sweetness and we had nothing particular in mind about venomous animals. It is quite possible, however, that occasional columns will concern themselves with actions of certain denizens of the national capital who would run everything from a desk in Washington. Perhaps *Theriaca Andromachi* could thus qualify under its ancient designation as an antidote to poisons and bites of venomous animals.

Actually, the only reason for reaching into the most ancient of medical history for a title was the fact that all descriptions of theriac refer to its fabulous variety of ingredients. Hence the "seventy or more" to which your dictionary refers. From that standpoint it seemed appropriate to carry the words *Theriaca Andromachi* at the head of a column, contents of which were expected to be many and varied.

No history of medicine is complete without some mention of the preparation called theriac. In one form or another it dominated the field of therapeutics more than two thousand years. Superstitions surrounding the preparation were not dispelled until the eighteenth century, when William Heberden of London wrote a book denouncing the concoction.

Rumor has it that when pharmacists of the Middle Ages made up a prescription they sometimes produced a little more than the required amounts. Excess was tossed into a jar under the counter. When the jar became full they would bottle up the mixture and sell it as theriac, a sort of cure-all. Note that in this humorous but probably inaccurate account emphasis is upon variety of ingredients.

Records indicate that the term was first coined by **Nicander of Colophon**. The word comes from the Greek, *theriakos*, which concerned venomous beasts or reptiles. Apparently this usage came about both because many of the formulae contained viper flesh and also because the mixture was recommended as an antidote. It is said that both **Pliny** and **Galen** affirmed that the formula for theriac of Nicander was inscribed in verse on stone in the temple of Aesculapius on the island of Cos, birthplace of Hippocrates.

Original compounder seems to have been the king, **Mithradates Eupator**, who did much experimentation with poisons, trying his preparations on slaves and prisoners of war. When he was vanquished his records were examined by **Pompey**, who obtained the prescription. The preparation then became known as *Confectio Mithradates*.

Second part of our historic title comes from the fact that the original formula of Mithradates was improved by **Andromachus the Elder**, archiater or royal physician to Nero. It was he who added squills, viper's flesh and opium.

Compounding of this famous medicine became a source of considerable civic pride and was accompanied by much ceremony. Communities vied with one another in their preparations but Venice became the source of the most celebrated of theriacs. Product of that city was much favored over those of Genoa, Florence, Bologna, Constantinople and Cairo. This explains the frequency with which one finds reference to *Venice Treacle* in connection with definitions of theriac.

It is interesting to note that the Venice preparation came into direct competition with a similar product made in England. There is record of a pamphlet issued in 1585 by one Hugh Morgan, Apothecary to Queen Elizabeth, which stated, "It is very lamentable to consider that strangers do dayly send into England a false and naughty kind of mithridatum and threacle in great barrells more than a thousand weight in a year and utter the same at a low price for 3 pence and 4 pence a pound to the great hurt of her Majestie's subjects and no small gain to the strangers' purses."

Helias, Patriarch of Jerusalem, sent to Alfred the Great of England much medical information including a glowing account of the virtues of theriac. He wrote, "Theriaca is a good drink for all inward tenderness, and the man who so behaves himself as is here said, he may much keep himself. On the day on which he shall drink Triacle he shall fast until midday and not let the wind blow on him that day; then let him go to the bath, let him sit there until he sweat; then let him take a cup, put a little warm water in it, then let him take a little bit of the Triacle and mingle it with the water, and drain through some thin raiment, then drink it, and let him go to his bed and wrap himself up warm, and so lie until he sweat well; then let him arise and sit up and clothe himself, and then take his meat at noon, and protect himself against the wind that day; then I believe to God it will help the man much."

Thus throughout the history of ancient and medieval medicine there runs the fantastic tale of *Theriac*. Through the ages it has been known by various names and to it have been attributed magic properties. Theriacum—triacum—treacle and finally the modern word molasses. Amusing, is it not, how the ancients believed in it? But wait—did not your own grandmother bring the ancient magic of theriac into modern times? Didn't you get your annual tonic dose of sulphur and molasses when you were a youngster back in Minnesota?

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Research Projects

Report on Research Work at the University of Washington School of Medicine

A considerable proportion of research carried on at the School of Medicine is made possible through the funds accruing to the university under Initiative 171 which authorizes sale of liquor by the drink in the State of Washington. The proceeds of licenses under this initiative are earmarked for biological and medical science research.

1. GASTRIC SECRETION AND EXPERIMENTAL PEPTIC ULCERATION: A COMPARISON OF THE EFFECTS OF ATROPINE AND BANTHINE UPON GASTRIC SECRETION AND EXPERIMENTAL PEPTIC ULCERATION

H. N. Harkins, M.D., and L. R. Sauvage, M.D.,
Department of Surgery.

Initiative 171 Funds.

Method: Forty-two Mann-Williamson dogs, two Heidenhain pouch dogs, a dog prepared for sham feeding and 100 Shay rats were studied.

Results: Banthine and atropine are both capable of preventing the cephalic phase of gastric secretion in the dog but banthine does this in a dose that is comparably much lower than atropine. Preliminary study indicates that neither has significant effect upon the hormonal phase. Either banthine or atropine will prevent ulceration of the gastric rumen in the Shay rat, but they are less successful in preventing jejunal ulceration occurring in the Mann-Williamson dog.

2. USE OF LIGHT MINERAL OIL AS A PRESERVATIVE SOLUTION FOR ARTERIES AND VEINS

H. N. Harkins, M.D., and L. R. Sauvage, M.D.,
Department of Surgery

Initiative 171 Funds

Method: Preserved venous autografts were implanted into the aorta of five young pigs. Preserved venous homografts were employed in twelve pigs. Preserved arterial homografts were implanted in the abdominal aorta of sixteen pigs.

Results: Most pigs are still living, but a few points can be made. Veins become unusable after about seventy days preservation in light mineral oil. However, arterial segments can be used after at least 180 days' preservation in mineral oil at 2 degrees C.

3. THE EFFECT OF SEVERAL HYDROCARBONS ON THE WEIGHT AND FUNCTION OF THE NORMAL PROSTATE GLAND

D. F. McDonald, M.D., Department of Surgery

Initiative 171 Funds

A study of the effect of several hydrocarbons and a large number of their derivatives on the weight and function of the normal prostate gland is being conducted. The goal of the study is an improved understanding of the mechanisms of action of certain compounds known to depress prostate function and weight. Compounds are screened for endocrine activity in spayed rats and in capons in order to eliminate hormonally active compounds which are not sought. The ultimate goal is medical management for prostatic hypertrophy.

4. BONE REPLACEMENT

R. D. Ray, M.D., Park Gloyd, M.D., James Degge, M.D., Garth Mooney, M.D., Department of Surgery

Initiative 171 Funds

Purpose: A comparative study of bone grafting materials.

The project has been divided into four phases. First phase dealt with a study of the reaction of the skeleton to basic calcium phosphate, a synthetic hydroxy apatite developed by Barrett of the Mellon Institute. The material was used to fill skeletal gaps created surgically in long bones of dogs. It was found that the material was well tolerated by the body and incorporated into the new bone formation. In the second phase of the project an attempt was made to determine a site where ectopic bone formation could be studied. Autogenous grafts were transplanted to skeletal musculature, the ventricle of the brain and the anterior chamber of the eye in rats, guinea pigs and rabbits. It was found that the grafts took in all sites. Since the incidence of spontaneous ectopic bone formation was low in the anterior chamber and fate of the graft could be followed grossly with an ophthalmoscope, this site was chosen for subsequent experiments. Third phase of the project dealt with a comparison of the synthetic hydroxy apatite, autogenous cancellous bone, callus from healing fractures and embryonic bone transplanted to the anterior chamber. It was found in some cases that both frozen and lyophilized bone survived and grew in the transplanted site. Next phase of the project will deal with the survival of bone grafts following varying periods of freezing and lyophilizing.

5. TREMOR

A. A. Ward, Jr., M.D., L. B. Thomas, M.D., and E. L. Foltz, M.D., Department of Surgery
G. D. Searle and Company Funds

By means of discrete lesions placed electrolytically in the mid-brain reticular formation of monkeys, a condition very similar to human Parkinson's disease can be produced, including the characteristic tremor associated with this condition.

Using this experimentally induced tremor a number of new drugs are being tested out with a view to finding some more efficient mode of therapy for Parkinsonism than is at present available.

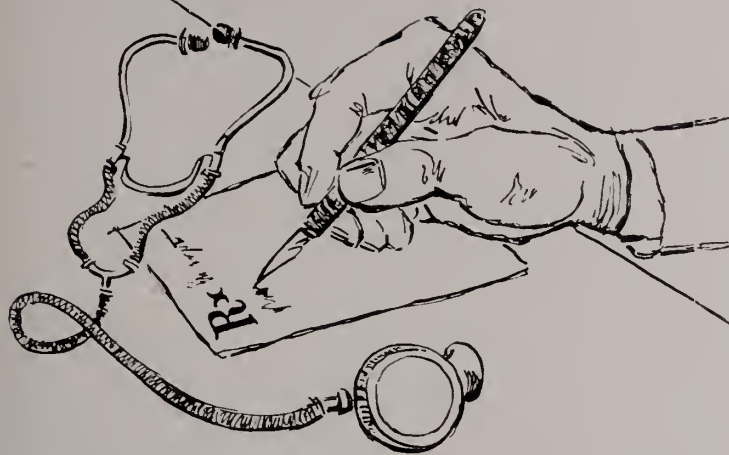
At the same time, recordings of the electrical activity of the brain stem reticular formation, the diencephalon and cerebral cortex in certain critical experimental conditions will, it is hoped, shed new light on the basic physiologic mechanisms involved in the disease process.

6. THE REPAIR OF DIAPHRAGMATIC DEFECTS WITH CUTIS GRAFTS

E. D. Geever, M.D., and K. A. Merendino, M.D.,
Department of Surgery

Initiative 171 Funds.

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This experiment concerns the study of cutis grafts in repair of manufactured diaphragmatic defects. The objectives are as follows:

1. To determine efficacy of internal use of cutis.
2. Comparison of free and pedicle autografts in repair of diaphragmatic defects of varying size.
3. Fixation of time required for complete healing.
4. Gross and microscopic study of viscera in juxtaposition to diaphragm repaired with cutis.
5. And finally the effects of 50 to 100 per cent replacement of the diaphragm by cutis in the experimental animal.

Sixty diaphragmatic defects were made in thirty dogs. The defects ranged in size from 50 square centimeters to 180 square centimeters (hemiresection). Equal numbers were repaired with free and pedicle cutis autografts. The thickness of the grafts was held constant at .020 inches by using the split-split method of removal. Penicillin was given for three days post-operatively and, after recovery from surgery, the animals were fluoroscoped. Necropsy specimens of the grafts and adjoining viscera were studied at intervals from the fourth postoperative day to four months. Studies will be made on other animals up to one year.

This project was stimulated by David Metheny, M.D., Seattle, who, in a personal communication, reported use of a free cutis graft as a diaphragm substitute after resection of a carcinoma of the stomach in continuity with the diaphragm.

7. POLIOMYELITIS

C. A. Evans, M.D., Department of Microbiology
National Foundation for Infantile Paralysis Funds

A major obstacle to progress of research on poliomyelitis has been the necessity of using monkeys. A big step towards overcoming this difficulty has been taken during the past two years in that the virus has been shown to multiply in tissue cultures. John F. Enders, M.D., and his associates of Harvard Medical School grew the virus in human embryonic tissue and in foreskin. University of Washington investigators were the first to show that the virus multiplies readily and in relatively large amounts in an adult human tissue (Smith, Chambers and Evans, *NORTHWEST MEDICINE*, 49:6, 368-371). Intensive research in five or six different medical schools, including the University of Washington, is now directed at exploring the usefulness of other tissues. It appears probable that use of tissues readily obtainable from surgery or autopsy will make it possible to use test tube experiments to accomplish much of the work on poliomyelitis that has required monkeys in the past.

The possibilities of getting a practical diagnostic procedure and an immunizing agent appear considerably brighter as a result of these developments.

8. ORGANIC PHOSPHATE INSECTICIDES

J. L. Sealey, M.D., Department of Public Health
and Preventive Medicine
American Cyanamid Company Funds

Field studies are being conducted in several counties in eastern Washington to determine toxic effects of Parathion, a commercial insecticide, which is being used extensively in the orchard industry. Previous reports in the literature have indicated that undue

exposure to this and similar insecticides has been followed by very deleterious effects.

9. DIPHTHERIA

V. J. Freeman, M.D., Department of Public Health
and Preventive Medicine
U. S. Public Health Service Funds

For the past two years a study of diphtheria phage has been carried on to determine its usefulness as a method of typing diphtheria bacilli. Further studies are being carried on in the study and development of a unified serologic classification of *C. diphtheriae* strains.

10. AIR POLLUTION STUDIES

J. L. Sealey, M.D., Department of Public Health
and Preventive Medicine
City of Seattle Funds.

For the past nine months a rather extensive study of the air pollution problem has been carried on in the City of Seattle. Results are presently being analyzed.

11. INFLUENZA

A. S. Lazarus, Ph.D., Department of Public Health
and Preventive Medicine
Initiative 171 Funds

The Virus Laboratory is investigating three different serologic tests for the detection of antibodies for influenza virus using vaccinated human volunteers. The purpose of this study is to determine the method most suitable for the early serologic diagnosis.

12. PROPERTIES OF NUCLEIC ACID IN NERVE TISSUE

W. K. Jordan, M.D., Department of Medicine
Initiative 171 Funds

Studies are being conducted on the properties of nucleic acids derived from nervous tissue and characteristics of the enzymes present in nerve tissue which influence nucleic acids. It is thought that Nissl substance, an important structure in nerve cells and a sensitive indicator of nerve cell malfunction, is composed of ribose, nucleic acid and a protein.

13. DETERMINATION OF THE RATE OF SYNTHESIS OF VARIOUS PLASMA PROTEINS IN CERTAIN DISEASE STATES OF MAN

W. Volwiler, M.D., Department of Medicine
U. S. Public Health Service Funds

Turnover rates of plasma albumin, gamma globulin and lipoproteins are being measured following labeling of the plasma proteins with oral tracer doses of S^{35} tagged cystine. Disappearance rates of passively administered I^{131} tagged human albumin are also being studied. Plasma protein fractions are obtained through cold-alcohol fractionation.

14. EFFECT OF VARIOUS GROWTH FACTORS ON THE SYNTHESIS OF PROTEINS IN SUBCELLULAR COMPONENTS

N. D. Lee, M.D., and R. H. Williams, M.D., Department of Medicine
Atomic Energy Commission Funds

Studies are being conducted on the effect of growth hormone, p-dimethylamino-azobenzene, and various diets on the incorporation of labeled cystine into subcellular components. It is believed that such studies will yield significant information regarding protein metabolism and hints on carcinogenesis.

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Book Reviews

TRANSACTIONS OF THE AMERICAN GOITER ASSOCIATION. 1950 Annual Sessions, March 9, 10, 11. Shamrock Hotel, Houston, Texas. 445 pp. Price, \$11.50. Charles C. Thomas, Springfield, Ill., 1951.

This book should be of value to anyone interested in diseases of the thyroid gland. It consists of seven sections, each one being a symposium on some phase of thyroid disease and dysfunction.

The first symposium on Diagnostic Methods and the Study of Human Thyroid Disease has some excellent papers. The paper by Dr. Bartels, of Boston, has a good practical discussion of the basal metabolic rate and plasma cholesterol as aids in clinical study of thyroid disease. There are some good discussions in this symposium on Protein-Bound Iodine Determinations. This excellent procedure is being used more often. There are also several good papers on use of radioiodine as a diagnostic method. In the symposium of Cancer of the Thyroid, the paper by Richard B. Cattell, of Boston, on the Indications for Neck Dissection in Carcinoma of the Thyroid should be read by everyone treating thyroid disease. Also to be noted in this section is a brief and a good discussion by Brien T. King, of Seattle, of the paper on Arytenoidectomy in the Treatment of Bilateral Abductor Vocal Cord Paralysis, presented by Wm. C. Thornell, of Cincinnati.

Other symposia presented were as follows: Radioiodine Treatment of Hyperthyroidism; The Toxic Effects of Radioactive Iodine; Adrenals and Thyroid Disease; Exophthalmos and Non-Toxic Goiter.

M. L. SCHOOLNIK

HOSPITAL STAFF AND OFFICE MANUAL. By T. M. Larkowski, M.D., F.A.C.S., Professor of Clinical Surgery, Stritch School of Medicine, Loyola University, Chicago, Ill. and A. R. Rosanova, R.Ph., M.D., Clinical Instructor, University of Illinois Medical School, Chicago, Ill. 428 pp. Price \$4.95. Romaine Pierson Publishers, Inc., Great Neck, N. Y., 1951.

This manual accomplishes what is intended by the authors: It presents a brief review and reminder of procedures, technics and also a brief review of medicine and surgery. Because of the immense field it attempts to cover, in many instances it is too brief to be practical, and therefore, probably should only be used as a guide for further reading and reference.

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THERAPY OF DERMATOLOGIC DISORDERS. Including a Guide to Diagnosis and a Dermatologic Pharmacopeia. By Samuel M. Peck, B.S., M.D., Dermatologist to the Mount Sinai Hospital, New York, Associate Clinical Professor of Dermatology, Columbia University, New York; Medical Director (Inactive), U. S. P. H. S., and George Klein, M. D., Associate Visiting Dermatologist, Morrisania City Hospital, New York; Acting Adjunct, Mount Sinai Hospital, New York; Assistant Clinical Professor of Dermatology, New York Medical College. 383 pp. Price \$6.50. Lea & Febiger, Philadelphia, Pa., 1951.

I found this little book very helpful and stimulating. It is divided into three main parts: A topographical guide to diagnosis, the treatment section, and a dermatological pharmacopeia. Like all doctors, I have yet to find any system to replace experience in diagnosis; however, the topographic method presented here is, of course, a help. The pharmacopeia is a unique feature; nowhere else have I come across so complete a list of standard remedies and prescriptions, including useful and new proprietaries.

However, the real contribution of the book lies in the central section devoted to treatment. Here each disease is introduced by a short clinical description followed by the treatment. These include the ones commonly used by the dermatologist and suggest the all-round management of the condition, both systemic and local. The remedies suggested are not merely a list of all those ever used but the ones commonly and currently employed in the dermatologist's office.

I would recommend this book both to the dermatologist as a refresher, and to the general practitioner as a practical everyday guide.

B. F. BRUENNER

PATTERNS OF DISEASE. By Frank L. Apperly, M.A., M.D., (Oxford), D.Sc. (Melbourne), F.R.C.P. (London). Professor of Pathology, Medical College of Virginia, Richmond, Virginia. 50 Figures and 37 Charts. 456 pp. Price \$8.00. J. B. Lippincott, Philadelphia, Pa., 1951.

This textbook is a slight deviation from the standard texts on pathology and physiology in that the pathology of disease is presented from the standpoint of changes in functions of organs rather than in their structure.

The author traces the progression of disease process step by step, noting first the biochemical changes, the altered function, the altered anatomy and finally the ultimate cure or death of the tissue involved.

He is concerned with compensatory mechanisms adopted by the body and their application to treatment of the disease.

The book is concise and, though rather oversimplified, is very readable.

ALICE G. HILDEBRAND

BACTERIAL POLYSACCHARIDES. Their Chemical and Immunological Aspects. By Martin Burger, formerly Organic Chemist to the Bureau of Laboratories, New York, New York. 272 pp. Price \$6.00. Charles C. Thomas, Springfield, Ill., 1950.

Treatment of the subject is very comprehensive starting with the production and extraction of the various polysaccharides and ending with their usage by slide, tube and skin test procedures.

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Information contained in this book is of limited clinical value. There are a number of tests described which are diagnostic, but not ordinarily performed and for which antigenic material is lacking.

C. L. HOFF

HEART DISEASE. Its Diagnosis and Treatment. By Emanuel Goldberger, B.S., M.D., Associate Attending Physician, Monrovia Hospital, New York; Cardiologist and Attending Physician, Lincoln Hospital, New York; Consulting Cardiologist, St. Joseph's Hospital, Yonkers, etc. 651 pp. 90 Illustrations. Price \$10.00. Lea & Febiger, Philadelphia, Pa., 1951.

Arrangement of this book into five main sections affords the reader easy and quick reference to any cardiac problem. The author stresses the importance of diagnostic procedures that may be performed in one's office or at the patient's bedside. He describes valuable shortcuts and observations that lead to accurate diagnosis of heart diseases. In discussing symptomatology and pathologic physiology, Dr. Goldberger has succeeded in presenting a clear, concise and readily understandable definition of each subject without using cumbersome and complicated explanations. However, oversimplification has been avoided and there are adequate discussions of all the recent advances and equipment in cardiology.

Although the author may emphasize his personal feelings in the choice of treatment, wherever differences of opinion may exist he presents all views on the subject. Each chapter in this book is followed by a well-organized and up-to-date bibliography.

The reviewer highly recommends this book as a ready and complete textbook for the busy general practitioner as well as for the cardiologist.

SAMUEL F. ARONSON

THE CLINICAL USE OF TESTOSTERONE. By Henry H. Turner, M.D., F.A.C.P., Clinical Professor of Medicine, School of Medicine, University of Oklahoma, Oklahoma City, Okla. 69 pp. Price \$2.25. Charles C. Thomas, Springfield, Ill., 1950.

This fifty-eight-page book is nicely bound and printed on heavy paper in a very readable type face.

First part of the book deals with the history, chemistry and physiology of this hormone in a very complete and technical manner. Remainder of the text deals with therapeutic use of the hormone with many clear illustrations.

The author has presented the subject in a very scholarly manner. For those who are interested in this subject, I think this is a good, short, concise and rather complete treatise on testosterone and a worthy addition to anyone's library.

C. J. PINARD, JR.

TREATMENT OF THE NEPHROTIC SYNDROME. By Lee E. Farr, M.D., Chairman, Medical Department, Brookhaven National Laboratory Hospital, Upton, Long Island, New York. 61 pp. Price \$1.75. Charles C. Thomas, Springfield, Ill., 1951.

The principal clinical problem in the treatment of the nephrotic syndrome is in the maintenance of positive nitrogen balance, and correction of edema. This short monograph is a review and an evaluation of the various methods used in the treatment of this syndrome.

The author discusses in a clear and understandable manner the relative values and abuses of salt restric-

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tion, alkalinizing therapy, acidifying salts, transfusions with albumen, gum acacia, gelatin and urea in the treatment of nephrotic edema. The author discusses in subsequent chapters the treatment of malnutrition, nephrotic crises and other complications, ending with a brief note on the use of cortisone, ACTH, and nitrogen mustard in the treatment of this disease. The monograph should be of practical value to general practitioners and internists.

MERRITT P. STARR

PAUL EHRLICH. By Martha Marquardt. With an introduction by Sir Henry Dale. 255 pp. Price \$3.50. Henry Schuman, New York, 1951.

Probably not even a wife knows the hopes and disappointments, the successes and failures, the bigness and the pettiness of a man as well as does a devoted secretary over a long period of years. At least so it seems with Martha Marquardt, secretary to Paul Ehrlich for fifteen years—as she tries to write an honest human biography of the great pioneer in chemotherapy.

It is reasonably well written—reads as easily as fiction (or should it be “more easily than most fiction”) and yet the writer was so close to both the man and the scientist that one gets a warm personal feeling of a great man who, despite his achievements, had the same foibles and was subject to and reacted to the little irritations of life pretty much as do you and I.

As a resume of Ehrlich's scientific contributions to the start and growth of biochemistry it is excellent. Most people think of Paul Ehrlich only as the dis-

coverer of the “magic bullet,” Salvarsan or 606, but his biographer, while detracting nothing from the importance of that profound scientific step, leaves no doubt that the real Ehrlich was a person of broad horizons—constantly searching for new applications for the thousands of fresh ideas which were constantly erupting from his ever-busy brain.

Once he said, “You know, I need never work out anything new at all. If I followed up all the thoughts and problems I have already noted down . . . I could keep a dozen chemical assistants busy with all the work for years.”

Whether for recreational reading, for an understanding of the very human Paul Ehrlich or for a scientific approach to his theories and contributions, the book, “Paul Ehrlich” is recommended reading.

R. N. DILLON

YOUR PROSTATE GLAND. Letters from a surgeon to his father. By Reed M. Nesbit, M.D., Professor of Surgery, University of Michigan Medical School, Chief, Section on Urology, University Hospital, Ann Arbor, Michigan. 50 pp. Price \$2.00. Charles C. Thomas, Springfield, Ill., 1950.

This book is a series of letters from a surgeon to his father who had a diseased prostate. The letters are written in terms easily understood by the average lay person, and present information which would help the person with prostate disease understand his condition. It is the kind of information the practicing physician would like to discuss with his patient, but usually cannot because he has insufficient time. This book can be recommended to the patient with prostate disease to give him facts which will help him understand his disease and more easily adapt to it.

EMIL S. DANISHEK

PARKINSON'S DISEASE. Advice and aid for sufferers of Parkinson's Disease and other physical disabilities. By Walter Buchler. 79 pp. Price \$2.00. Walter Buchler, London, England.

This book has been written by an individual afflicted with Parkinsonism, for the benefit of other sufferers in order that they may have an insight into their disease. He points out that, although the muscles are disabled, memory, reasoning, and other mental faculties are not impaired and that study into new fields of endeavor by occupying the mind with active, fruitful thoughts dispels brooding. How often is improvement seen in the patient when the



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Though this book was written by a layman and contains some misinformation, as classifying hyoscine, benadryl, amphetamine, pyribenzamine and belladonna as barbiturate drugs, it contains much of value to the physician who is called upon to treat this disease by presenting in detail how the symptoms of the condition affect the daily routine of the patient. This small volume is easily read and is recommended to the individual suffering from Parkinsonism, that he may take encouragement and by regulating his activities best adapt to the limitations placed upon him.

EMIL S. DANISHEK

MEDICAL NEUROPATHOLOGY. By I. Mark Scheinker, M.D., Assistant Professor of Neuropathology and Assistant Professor of Neurology, University of Cincinnati College of Medicine, Attending Neurologist, Cincinnati General Hospital, Cincinnati, Ohio, etc. With a Foreword by Marion A. Blankenhorn, M.D., Professor of Medicine, University of Cincinnati College of Medicine, etc. 372 pp. Price \$10.00. Charles C. Thomas, Springfield, Ill., 1951.

In the volume the author discusses neuropathology primarily from the viewpoint of the internist, and for that reason its scope is somewhat limited. Four of the nine chapters deal with vascular disease of the brain. The remaining chapters cover cerebral reactions to intoxicants and blood dyscrasias; and the cerebral manifestations of lung and liver diseases. Those areas that are covered are quite comprehensive and substantiated by an excellent bibliography of 313 references.

Main body of the volume is composed of an exhaustive survey of the author's work on cerebral vascular disturbances. Dr. Scheinker has developed a dynamic concept of the pathologic physiology of the cerebral circulation, emphasizing the reversible changes that occur and promulgating the importance of vasospasm, vasoporosis and vasoparalysis in development of frank cerebrovascular accidents and lesser vascular disturbances. His formulation is appealing and progressively gaining acceptance, even though experimental evidence is somewhat meager. His theories are a great stride forward in the understanding of circulation of the brain.

The volume describes the pathologic changes in the various conditions and ties them to clinical medicine with numerous case histories. It is beautifully written, with an exceptionally clear format and excellent plates of gross and microscopic pathology. It should be a much-used reference and anyone dealing with medical neurology should be familiar with it. It fulfills its intended purpose admirably but to the clinical neurologist its narrow scope is somewhat disappointing. Also in emphasizing reversible cerebrovascular changes the author fails to warn his reader that these disturbances are frequently the presenting symptom in brain tumor, multiple sclerosis, aneurysms and other discrete neurologic diseases. The unwary impressed with the diagnosis of cerebral vasospasm may stop short of a final accurate diagnosis.

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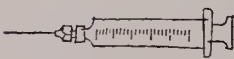
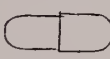
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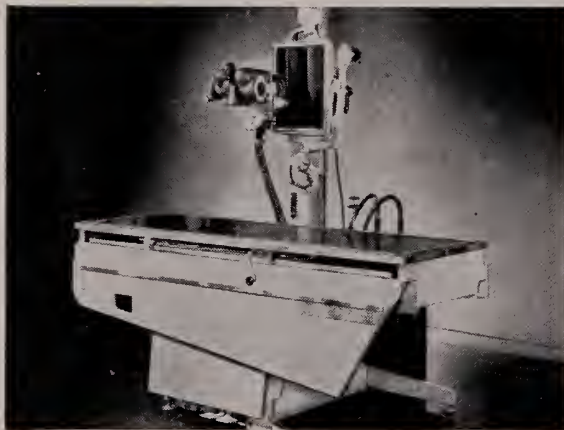
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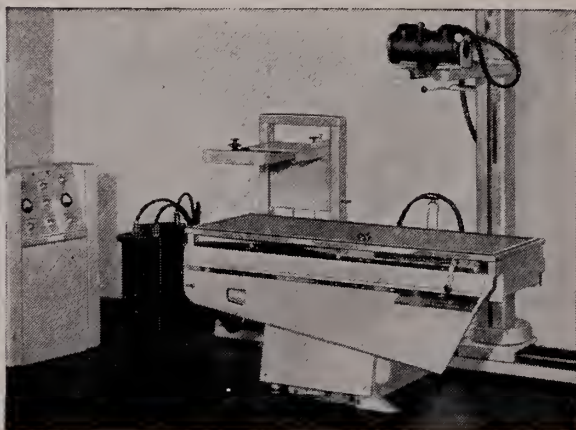
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*Reference: MacBryde, C. M., et al., *A New Synthetic Estrogen*, J.A.M.A., 123: 261; 264-102) 43.

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Hamblen, E. C.: Some Aspects
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North Carolina M. J.
7:533 (Oct.) 1946.

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Wright, L. T., et al.: Antibiotics and Chemotherapy 1:165 (June) 1951.

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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. 139:897 (Apr. 2,) 1949



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Friedman¹ deplores the tendency to call any chronic recurring headache migraine. Careful history-taking and full physical and neurological examinations are essential for accurate diagnosis. A good starting point is a description of the headache — its character, laterality, frequency and intensity.²

The following chart gives briefly the primary diagnostic leads and treatment for the most common types of headache.

Etiology of Headache	Primary Diagnostic Data	Primary Therapy
Inflammatory e.g., Meningitis Abscess	Inflammation of intracranial structures; fever; leucocytosis; bacteriologic diag.	Specific: sulfonamides and antibiotics. Symptomatic: analgesics.
Tumor	Pain varies as spinal press. changes; skull X-ray.	Specific: surgery. Symptomatic: analgesics &/or hypnotics.
Sinusitis	Sinus congestion and infection; cloudy X-ray.	Specific: antibiotics and drainage. Symptomatic: analgesics.
Hypertensive	Hypertension present but pain not related to b.p. level; Dihydroergotamine relieves pain.	General hypertension therapy; sedation. Symptomatic: analgesics.
Migraine & other vascular headaches	Headache: recurrent, intense, throbbing. No organic causation; migraine in family; patient: energetic, perfectionist. Visual prodromata; g-i. upset during headache.	To abort attack: oral ergotamine plus caffeine. General: adjustment to minimize nervous stress.

Data here tabulated is from: Wolf, G., Jr.,³ and Friedman, A. P.⁴

Cecil⁵ ranks vascular headaches, e.g., migraine and tension headaches, as the most commonly encountered of all. Because of their functional nature and usual recurrence at frequent intervals, they present a long-term therapeutic problem.

Therapy is conducted along two lines:

1) *Psychotherapy to reduce the frequency of attacks. This consists mainly of advice on emotional adjustment to stressful situations and guidance toward a good balance between work and relaxation.*

2) *Treatment of the distressing attack to prevent the usual period of incapacitation. Many investigators have reported that ergotamine preparations are effective for relief of the acute migraine attack in 80% of cases.^{1,6} The drug is given immediately when an attack is approaching and dosage adjusted to the needs of the individual.*

1. Friedman, A. P. and von Storch, T.: 99th A.M.A. Session, June 1950. 2. Butler, S. and Hall, F.: M. Clin. N. Amer., p. 1439 (Sept.) 1949. 3. Wolf, G., Jr.: M. J. 54:25, 1951. 4. Friedman, A. P. and Conn, H. T.: Current Therapy, 1950, p. 563. Saunders Co., Phila. 5. Cecil, R. L.: A Textbook of Medicine, ed. 7, 1948, p. 1483; Saunders Co., Phila. 6. Horton, B. et al: Staff Meet. of Mayo Clinic 20:241, 1945.

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Ontario	Portland
Washington State Medical Association.....	1952
President, K. L. Partlow	Secretary, J. W. Haviland
Olympia	Seattle
Idaho State Medical Association.....	Sun Valley—June 15-18, 1952
A. M. Popma	Secretary, R. S. McKean
Boise	Boise
Alaska Territorial Medical Association.....	Anchorage—June, 1952
President, H. Romig	Secretary, W. P. Blanton
Anchorage	Juneau

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NORTHWEST

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Seattle	Portland
North Pacific Pediatric Society	
.....Harrison Hot Springs, B. C.—Sept. 21, 1951	
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Vancouver, B. C.	Portland
North Pacific Surgical Assn.....	Vancouver, B. C., Nov. 16-17, 1951
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Portland Surgical Society.....	Last Tuesday
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Portland	Portland
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WASHINGTON

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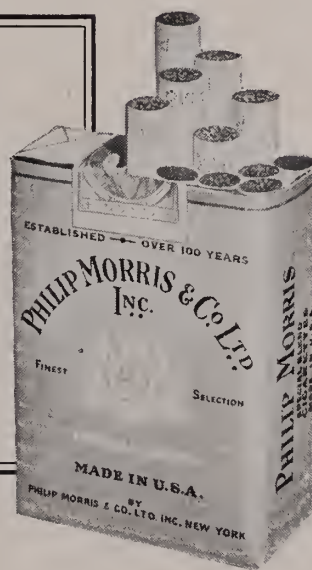
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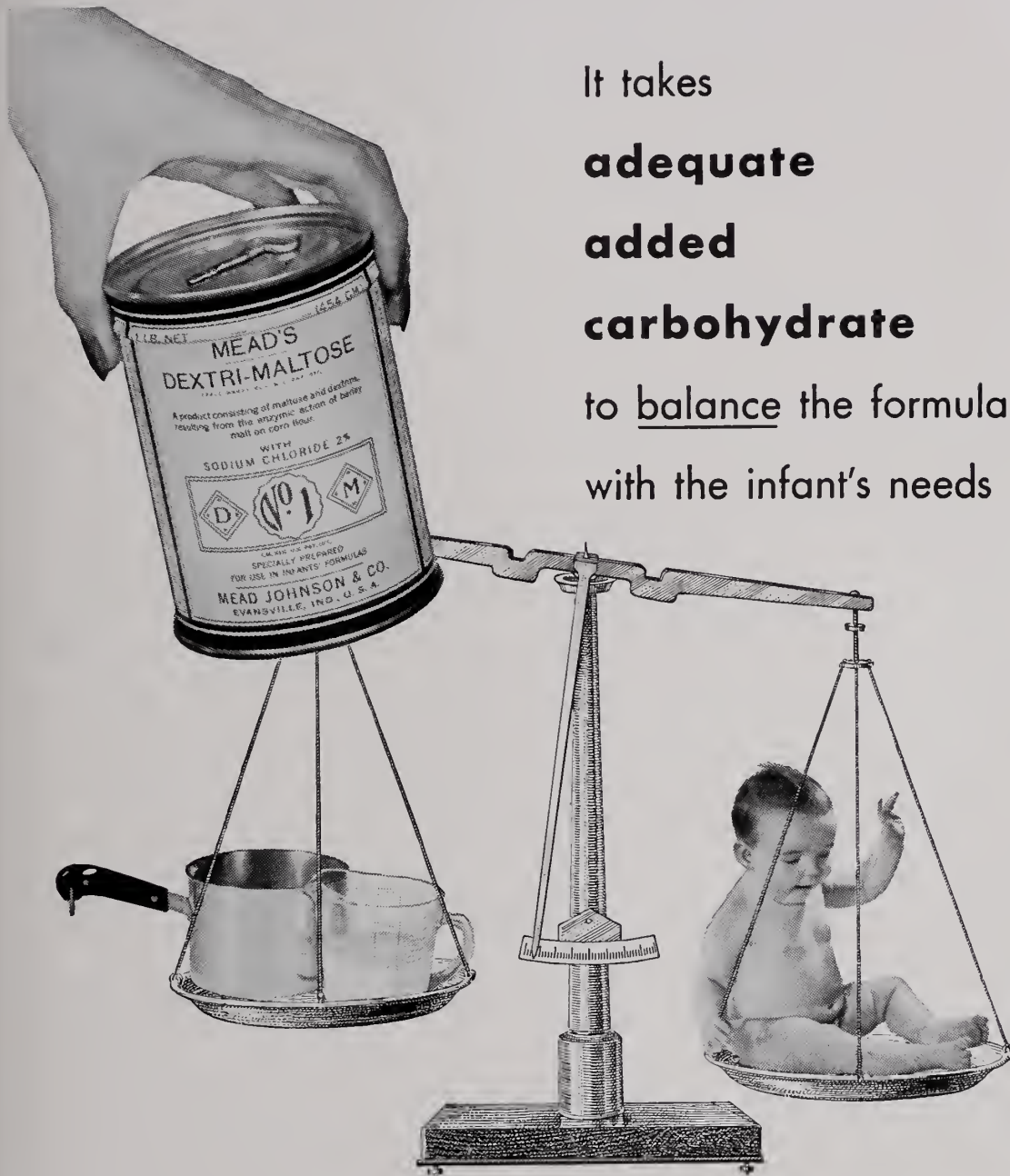
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OCTOBER, 1951

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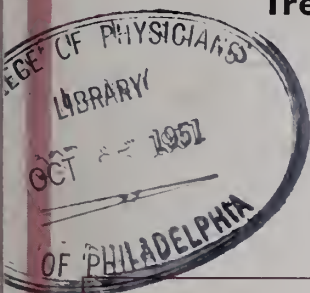
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*Cutting, W. C.: A Manual of Clinical Therapeutics, ed. 2, Philadelphia, W. B. Saunders & Co., 1948, p. 484.

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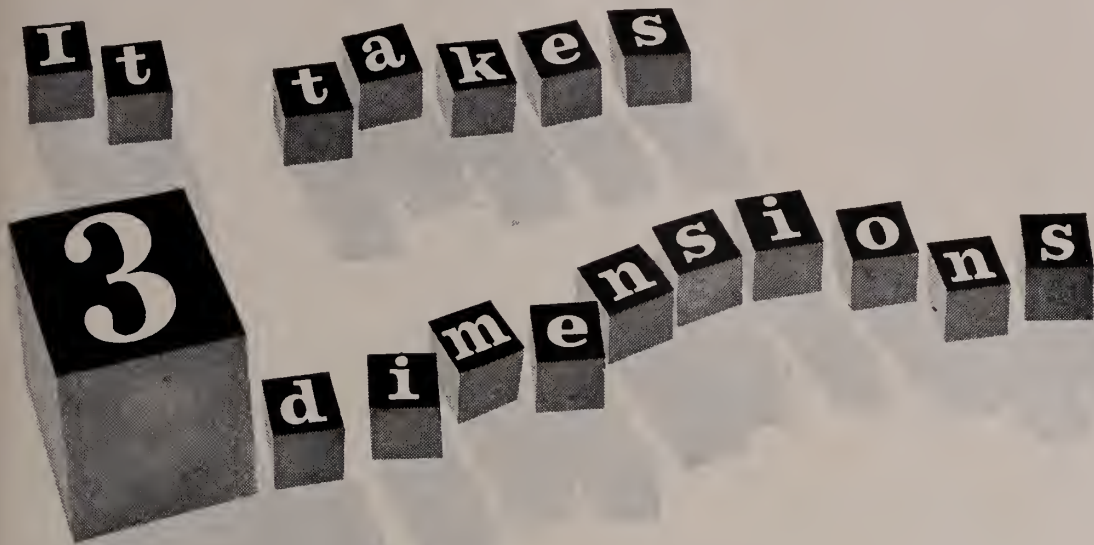
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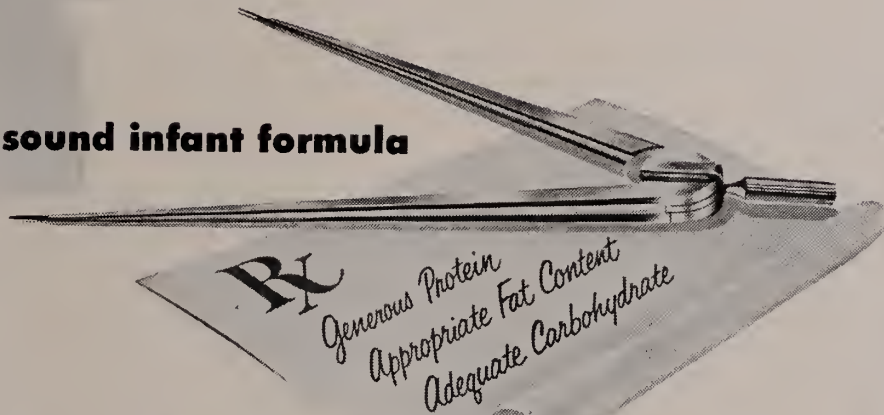
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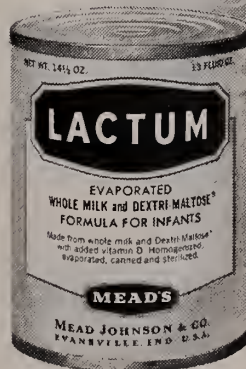
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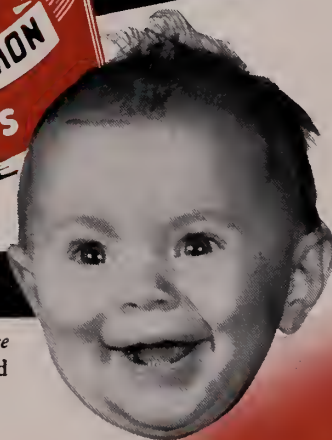
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*Wilbur, D. L.: Principles in the
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From *Blakiston's New Gould Medical Dictionary*: "Theriaca Andromachi. Venice treacle, a compound containing nearly 70 ingredients . . ." See *NORTHWEST MEDICINE*, 50:708, Sept., 1951.

PR BEGINS AT HOME. District of Columbia Medical Society thinks maybe its own members need a little public relations. They are holding a series of luncheons for small groups of members. These groups of not more than thirty are given brief but pertinent information on the society, its aims and objectives and current operations. Mr. Theodore Wiprud, their well-known executive secretary, says " . . . each doctor leaves with a clearer conception of the importance and value of his medical society." We know a few societies that might well use a little of that kind of buildup.

PATHOLOGISTS START STANDARDIZATION PROGRAM. The College of American Pathologists has announced a program of standardization to improve efficiency and increase uniformity of medical laboratory tests. First on the program will be provision of accurate solutions for preparation of test materials by individual laboratories. Similar solutions will permit standardization of testing procedures or will serve to check performance of individual technicians. The college anticipates that all branches of laboratory work will eventually be included in the program.



OSCAR GETS THE DOUGH. Small wonder that *Bacillus Bigshotitis* hits hard when you note the kind of moola that Mr. Ewing's department gets to throw around. President Truman signed the bill August 31 which labeled more than a billion bucks for the Federal Security Agency for fiscal 1952. Sample allocations: Venereal disease, \$11,653,360; communicable diseases, \$5,915,747; hospital construction, new, \$82,500,000; hospital construction, completion, \$100,000,000; hospitals and medical care, operation, \$30,200,000; National Cancer Institute, \$19,500,000; mental health activities, \$9,518,987; Children's Bureau, grants to states, \$31,500,000.

NO CHANGE IN POLIO. Total cases of polio through August 25 this year were 11,561. Last year, same date, 11,624.

BAR GETS SOCIALIZATION JITTERS. Whitaker & Baxter report many bar associations are asking for copies of "Simplified Blueprint of Campaign." Lawyers in all parts of the country seem to be getting the idea that it could happen to them, too. As you might expect, California is out in front with government programs edging in on the practice of law.

IDEAS WELCOME ON 12-POINT PROGRAM. Walter B. Martin's committee to revise the A.M.A. 12-point program will meet at the Statler, New York, October 27. Representatives of county or state organizations may appear or send letters. Dr. Martin's address, 229 W. Bute Street, Norfolk 10, Virginia.



PHYSICIAN DRAFT CALLS PIGEONHOLED. Calls for Priority 1 physicians during August and September were deferred. Setup was to have been for 333 in August and 152 in September. Volunteers for active duty plus applicants for reserve commissions have been adequate to meet needs.

REMBER RESEARCHES IN PR. Macon County (Illinois) Medical Society is the guinea pig for a PR research plan. Mr. Larry Rember of the A.M.A. Public Relations Department is conducting a study at Decatur to determine what the public thinks about its medical service. Facts obtained will be turned over to the local society—knowledge gained will be used in advising other societies how to do it.

BENEVOLENT BUREAU BESTOWS. With hats in hand, hospitals and other health claimants have been begging for more steel and copper. Defense Production Administration has shuffled its cards and comes up with 7,500 tons of steel added to fourth-quarter quota and 450,000 pounds of copper. Some medical equipment manufacturers have had style badly crimped by restrictions.



ACTH PRICE CUT. Armour Laboratories announced a 25 per cent price reduction effective October 1. Increased yield due to improved processes is given credit for the change.

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Sayer, R. J.; Michel, J.; Moll, F. C., and Kirby, W. M. M.: Am. J. M. Sc., 221:256 (March) 1951

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Correspondence

To the Editor:

When our friends say or write things about us, we are apt to receive them with greater equanimity than when they are written or said by strangers. This is in explanation of the fact that I read the July 10 editorial in the *Statesman* without becoming particularly disturbed by it, although it made several statements with which I was not in agreement. Charles Sprague, the editor and owner, is a staunch supporter of medicine, although a man who is not averse to pointing out our weaknesses when he sees them.

The editorial in question was not written by Sprague but was written by a young lady on his staff and, although he read it and okayed it for publication, I have a feeling, after discussing it with him, that he feels that he might have checked it more carefully than he did. I have also discussed the editorial with the author and find that, although she too is a good friend of the profession, she has some views which differ from ours, the chief one being that she feels the medical profession should carry on a constant and active crusade to purify all M.D.'s. I had a long discussion with her after receiving your note and I think I have changed some of her ideas. Her editorial confuses M.D.'s and chiropractors, not because she is not fully aware of the difference but because of careless writing.

... I feel this unfortunate editorial represents a mistake on the part of the editorial staff of the *Statesman* which does not truly represent their views of the medical profession and, although the remarks actually constitute slander and insult, I know that such was not intended.

Very truly yours,

W. W. BAUM
Salem, Oregon

To the Editor:

When I received the proof of your editorial commenting upon an editorial recently appearing in *The Statesman* of Salem about the abortion mess in Portland, my impulse at first was to do a Gromyko and say "no comment," for I think that irresponsible statements are best left alone without being argued very much. However, the *Salem Statesman* has a reputation for conservatism and factual reporting and is owned and controlled by ex-Governor Sprague, who is a man of like reputation.

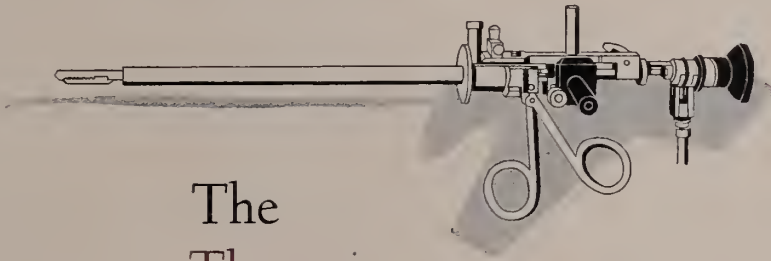
I cannot understand how a man like Governor Sprague would write or allow to appear in his paper an unauthenticated statement smearing a profession without first obtaining the facts and certifying to them. If it were true that the doctors do keep their profession disciplined and try to take care of the sins within it, I think a better job could be done than is done now, but wherever we have made any concerted attempt to clean out our ranks we are interfered with by the legal profession and public reaction. The history of the activities of the medical profession in

(Continued on Page 798)

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Gray, L.: J. Clin. Endocrinol. 3:92 (Feb.) 1943.

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EDITORIALS

Ewing's Newest Plan

The following discussion of Mr. Ewing's plan to provide hospitalization for those over 65 is quoted direct from release by the Federal Security Administration.

This program would provide hospitalization insurance for those persons who are beneficiaries of old-age and survivors insurance and for those who are eligible but have not yet applied for cash benefits. In contrast to the population as a whole, these groups have greater need for hospitalization, smaller resources for meeting the costs of illness on an individual basis and less opportunity to obtain private insurance to soften the impact of these costs.

THE BENEFICIARIES

Those who would be eligible for hospitalization insurance benefits consist of aged persons insured under the old-age and survivors insurance program—whether or not actually drawing benefits—and their dependents, and the surviving dependents of workers who were insured when they died. These groups would now total about 5.5 million persons. Next year they would equal about 6.3 million and two years from now nearly 7 million. Such a rapid increase in the next few years is due mainly to the unusual expansion in the number of workers insured under the old-age and survivors insurance program as a result of the 1950 act which liberalized eligibility requirements and extended coverage to about 10 million additional jobs. A small part of the increase results from the continuing growth in the number of aged persons in the population.

Because an unusually rapid increase is to be expected in the immediate future, an analysis of the group that would be eligible for hospitalization insurance and of the cost of the proposed program is more reasonable in terms of coverage in, say, 1953 than as of the present date or next year. The number insured would continue to increase gradually but more slowly for many years after 1953.

Of the nearly 7 million estimated to be eligible about two years from now—the middle of 1953—almost 5.5 million would be persons in ages 65 and over. More than half of this aged group (2.9 million) would be primary beneficiaries of the old-age

and survivors insurance system. Wives aged 65 and over and dependent husbands would add another 0.9 million. Just over half a million would be on the benefit rolls as the aged widows, dependent widowers or parents of workers who died “fully insured.” All together, these aged beneficiaries of the old-age and survivors insurance system would total about 4.3 million. The remainder of the age 65-and-over group who would be eligible for hospitalization insurance consists of about 1.0 million “fully insured” individuals who would still be at work and would not yet have filed for monthly benefits, and those of their wives or dependent husbands who would be over 65 (an estimated 0.2 million).

In addition to the 5.5 million eligibles in ages 65 and over, there would be about 1.1 million children and nearly 0.4 million mothers who would be insured for hospitalization. About nine-tenths of the children would be entitled to monthly benefits as the survivors of deceased insured workers; the other tenth would be the children of “primary” old-age beneficiaries or of “fully insured” workers aged 65 and over but who had not yet claimed retirement benefits. Of the nearly 0.4 million mothers who would be eligible because of having children in their care, five-sixths would be widows and the other sixth wives of “primary” beneficiaries and other “fully insured” men in ages 65 and over.

WHY THEY NEED INSURANCE

For families dependent on old-age and survivors insurance benefits, hospitalization costs can be a disastrous blow to the budget. Even after the substantial increase in the benefit level enacted last year, monthly benefits in current-payment status at the end of April, 1951, averaged about \$43 for all old-age “primary” beneficiaries, about \$67 for an aged couple, about \$36 for aged widows and about \$90 for a widow and two children.

Benefit checks in these amounts cannot be stretched to cover the unpredictable and heavy expenses of illness requiring hospitalization. Neither do they leave much over, after paying for essentials like food and housing, for the purchase of hospitalization insurance on a private basis—even assuming

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that such insurance is available to the beneficiary groups.

When beneficiaries incur expenses for hospital care they have to draw heavily and unexpectedly on their assets, get help from relatives or from private charitable or public welfare agencies, or incur debts. In a 1944 survey in Ohio and St. Louis, from two-thirds to six-sevenths of the various aged and survivor beneficiary types reported having had some medical or hospital care during the survey year.

Many beneficiaries apparently cannot afford the care they need and hence go without it. As they grow older, their need for medical and hospital care increases while their incomes and assets decline. The same survey showed that only an occasional beneficiary has assets (other than an equity in a home) which would last his expected lifetime if used at a very modest rate.

Retirement is not infrequently precipitated by ill health. If such forced retirement is preceded by a serious illness requiring hospitalization, the medical and hospital costs may use up savings which have been carefully accumulated for the purpose of supplementing the expected retirement income.

Older persons prefer to stay on the job as long as they can. It is to their advantage, and to the advantage of the whole national economy, that they do so. The existing old-age and survivors insurance system is frequently criticized on the ground that it penalizes aged workers by withholding their benefits while they continue to work, without any future compensatory increase in the retirement amounts. In the face of arguments for relaxing or abolishing the retirement test and in a period when defense production requires all our manpower, it would be unwise to make hospital benefits contingent upon retirement, since this would encourage withdrawal from the labor force. This is one of the reasons why the proposal covers aged persons who have not yet retired, provided that they are "fully insured." Many of them will be able to stay in the labor force if they have hospitalization insurance.

WHY THEY NEED PUBLIC HOSPITALIZATION INSURANCE

Most private insurance against hospitalization costs is based on the principle of spreading the risk through enrollment of *groups* of persons who, taken

together, will have average needs for hospitalization. Most of the beneficiaries of the proposed plan do not come within the scope of generally recognized groups and they have unquestionably higher-than-average hospital needs. It is very difficult, if not impractical or impossible, for private insurance to cover them at premiums they can afford to pay.

ESTIMATED COSTS

For calendar year 1953, taxable wages and self-employment income under old-age and survivors insurance—with the present \$3,600 ceiling—are estimated to total about \$141 billion. Thus the cost of the proposed plan (\$187 to \$230 million) would amount to more than one-tenth but less than two-tenths of 1 per cent of taxable payroll (0.133 to 0.163 per cent) for that year. If price and wage levels change and the average cost of a day of hospital care increases or decreases, taxable wages would also change in approximately the same proportion, and these percentages would still apply.

Costs of this size would not in themselves justify an increase in the statutory contribution rate for the old-age and survivors insurance program because of adding hospitalization benefits. (The law now provides for contributions that will reach $6\frac{1}{2}$ per cent in 1970, equally divided between employers and employees.) Also, these costs are well within the means of the present insurance system, with its present financial provisions. Although the costs of hospitalization insurance would be expected to increase in future years—becoming about two-tenths, possibly three-tenths of one per cent of taxable payroll—they would not of themselves present a substantial reason for changing the contribution rates for many years to come—if at all.

THE FUNCTIONS OF THE FEDERAL SECURITY ADMINISTRATOR

The administrator would make the necessary regulations relating to the program in general, acting on these and all policy matters with the advice of the Federal Hospital Council. Determination as to an individual's insured status under the hospitalization insurance plan would be made in the same manner and from the same records as determinations for cash benefits are now made under the old-age and survivors insurance program.

Professional Advising

A good many students go to college today without too clear-cut an idea of just why they are attending an institution of higher education. In some cases it is because it is a fashionable thing to do and in other cases it is simply because the student or the family had planned it that way. It is not surprising

that a certain percentage of young people in their late teens have not yet reached a decision as to the type of thing which they would like to do as a permanent life activity. On the other hand, there are many students who have precise objectives. They know exactly what they wish to do and the type of

academic training they need to attain their objectives. One is not too concerned with the latter group of students unless, during their academic careers in college, they demonstrate, through accomplishments, that they have made a mistake and should shift to some other field of activity.

It is the former group of students, who have not yet truly determined what their objectives should be, who present the problems of greatest concern. This is where a basic course in general education is sometimes exceedingly helpful in aiding the student to choose the field in which he would like to major later on. This is the group also where advice and counsel is exceedingly valuable.

A few years ago there were unusually large numbers of premedical and predental students registered at the University of Washington. In 1945 apparently there were over a thousand such students. Many of these individuals had simply signed up for premedical majors or for majors in basic medical science because it was a popular thing to do and not because they had thought it through carefully.

Some of those students were bound to be disappointed later. Many were studying in these fields without any very strong convictions one way or another. Not all would be able to gain entrance to

medical or dental school. Thus the large numbers of premedical and predental students almost guaranteed frustration for some.

The College of Arts and Science of the University of Washington developed a program during the past few years through which efforts have been made to help young people who are interested in preprofessional training. Efforts were made to encourage individuals who showed very definite aptitudes in areas of importance to medicine and dentistry. Likewise, efforts were made to help individuals who did not show particular aptitude in these areas to determine areas in which they were best qualified. In order to avoid the heartaches and disappointments that go with failure to be admitted to medical school, the students who obviously were demonstrating no particular aptitudes in the area of premedical or predental training were encouraged to make readjustments. They were advised to get into other fields of activity where there was a greater promise of success. Such advising has reduced the over-all number of premedical and predental students and has improved opportunities for those who show very real abilities in these areas. Thus, one of the important functions of preprofessional training is to help students find themselves and their major interest.

Intern Matching Foolishness

With the announced worthy purpose of bringing together internships and medical students seeking them, a strange creature has been quietly presented to an unsuspecting medical profession. Upon closer examination it holds high promise of disrupting or completely wrecking the fine relationships and accomplishments of the present internship program which has contributed so much to good medical training and care.

The creature bears the high sounding name of *The National Interassociation Committee on Internships*. Acceptance of its proposals would effectively terminate the present regular cooperative, but free and voluntary, plan for intern appointments, and replace it with a plan which to say the least is not pleasing to the end organ of the first cranial nerve.

The program sounds plausible. There are a known number of appointments for interns in our hospitals and a recurring crop of medical graduates who seek them. At present the supply of appointments exceeds the number of applicants, but that is incidental. The basis of the plan is that student applicants would furnish the new committee with the high-sounding name, a list of their preferences in hospitals for internships. Hospitals in turn would

list with the committee their preferences in students applying for internships. The committee would then "match" the one against the other and everyone would be happy.

Or would they?

Investigation of the committee's genesis, composition and activities at this distance from its Chicago headquarters has not been easy. A considerable number of articles and other literature have been published by or about the committee and its proposals, but, for the most part, these are so vague and indefinite on essential matters, except the mechanical workings of the proposals, as to suggest the organization could profitably be subjected to the most careful scrutiny.

A committee bulletin states: "In December of 1950 an Ad Hoc Committee was established under sponsorship of the Committee on Internships and Residencies of the Association of American Medical Colleges for conducting an experiment in the method of appointing of interns.

"The new committee was composed of representatives from the American Catholic Hospital Association, the American Hospital Association, the American Medical Association, the American Protestant

Hospital Association, and the Association of American Medical Colleges with liaison members from the governmental agencies concerned with internships."

The purpose of the committee was announced to be the conduct of a trial run for matching preferences of students and hospitals in internship appointments.

On May 23, 1951, the committee reviewed the results of the experiment, concluded "this proposed matching system can be operated successfully *as far as the mechanics are concerned*." (Emphasis ours—Ed.) On the strength of this test run it was therefore recommended "that the matching plan be adopted as the official method of intern appointment for next year." Since it appears the committee considers its recommendation the equivalent of enactment, the present turmoil confusing the internship picture is with us.

Most of the bulletins and much of the literature carry the names or signatures of F. J. Mullin as chairman, and John M. Stalnaker as director of operations for the committee. Professor Mullin appears to be the Dean of Students, University of Chicago School of Medicine and a holder of the Ph.D. degree. Mr. Stalnaker is reported to be Director of Studies for the Association of American Medical Colleges, the executive officer for the new committee and presumably is also a layman.

Notable feature of the affair is the failure to state in any writing which has come to our attention, the exact representation enjoyed by the respective organizations indulging in the proposals, or how the voting, if any, is done. Information available at this time indicates one representative each from the religious hospital associations, two from the American Hospital Association, two from the A. M. A. Council on Medical Education and Hospitals, three from the Association of American Medical Colleges, and two votes among five representatives of the federal agencies.

If this weighting is correct, and it seems to be in keeping with the composition of the committee, the purely medical forces in contradistinction to educational, hospital and federal agencies are sadly outnumbered.

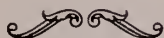
Federal agencies include the Air Force, Army, Navy, Veterans' Administration and the inevitable Federal Security Administration, for its Public Health Service. It is reported that a total of eleven liaison officials of these agencies are eligible to attend the committee meetings, although they are said to be restricted to two votes.

The proposals promulgated by this strange committee are considered by a number of hospitals, and many doctors, to have been "sprung" upon them. They dislike the rigid time-schedule with which they have been confronted: Hospitals register by September 15, medical school deans indoctrinate their seniors between opening of school and October 15; students send preference list and \$2.00 to committee before November 1, 1951, etc. They also dislike the carefully veiled but easily discerned "or else" intimations that noncompliance with the matching program will involve withdrawal of approval of internships by the Council on Medical Education and Hospitals.

The matching plan and the "quota" system are stated to be unrelated, but to anyone who makes a study of the two it is obvious there is an inescapable basic relationship whether or not the committee and the Council on Medical Education and Hospitals are willing to admit it. Without at least one fixed item, in this instance the number of approved internships, the matching plan could not hope to work.

A most disturbing aspect of the affair is the role played by the A. M. A. Council on Medical Education and Hospitals. There is no excuse for a responsible branch of organized medicine being a contributor to fashioning the noose around our own necks, or failing to utter timely and adequate warnings of what is going on. An inquiry along these lines would be a fitting task for the forthcoming meeting of the A. M. A. House of Delegates in Los Angeles.

In the meantime the proposals should be dropped forthwith. The ill-conceived, unnecessary and costly so-called "experiment" smells so strongly of regimentation, aggravated by the soft-headedness which would accept and abet self-imposed regimentation at that, that we want absolutely no part of it.



ORIGINAL ARTICLES

I Remember When*

GEO. O. A. KELLOGG, M.D.
NAMPA, IDA.



The stable I patronized. Note the two freighters pulling out for the interior.

I CAME to Idaho rather late in the horse and buggy days and, while my experience was limited to a few years, they were full years and covered a lot of territory.

I used my single driver (Mingo) within a radius of three or four miles, a livery team within a distance of forty miles, and Wells-Fargo and privately owned stage lines for greater distances.

I had my own heavy mountain buggy which I kept packed with sterile supplies and equipment, including fishing tackle, shotgun and rifle. I would add my surgical bag, obstetrical bag and medicine case and be prepared for any emergency.

The telephone lines followed the main roads, permitting me to check them as I drove along, and also make simple repairs. The switchboard girl kept a record of my calls and we would exchange information upon my return. In appreciation of this service, the manager presented me with a small chest containing a repair kit, climbers and test set, which enabled me to get Central from any telephone pole in the interior.

Upon receiving a long call, I would state the exact time of my arrival at the nearest stage station and they, in turn, would arrange my schedule. I used a relief driver from the livery stable on these long, rugged trips.

At the station we were met by hostlers with a fresh team hitched to a neck-yoke and the change

would be made in a matter of seconds. The stations were spaced to permit running a team from station to station. Should we desire food or drinking liquor, the order would be phoned ahead and picked up at the next station.

There were many factors contributing to the remarkable success of this type of practice. To mention a few:

1. The patients were tough outdoor men and women, inured to hardship and more or less immunized to the local bacterial flora.
2. Constant observation of the patient until he or she died, or recovered sufficiently to be left in the care of an instructed layman.
3. Intelligent first aid care.

There were two publications found in every ranch home, The Doctor Book and Montgomery Ward



The author and Mingo.

*Read before a meeting of the Boise Chapter of American College of Surgeons, Boise, Ida., Dec. 9, 1950.

catalogue, each in their own special niche. The Doctor Book in the parlor, Monkey Ward in the Chick Sale four holer. Dr. Gunn's chapter, "What to do until the Doctor comes" was invaluable—the remainder of the book, a damned nuisance.

I was called 250 miles to a ranch near Denio to treat an incomplete abortion, hemorrhaging from retained placental tissue. She had been kept flat in bed, the foot of the bed well elevated, on liquid diet and forcing fluids.

The ingenuity shown by the natives, on occasion, was really something rare. I was called to a large cattle ranch above Drewsey, Ore., to treat a buckaroo. His running cowpony had stepped in a badger hole, breaking the pony's front leg and the cowpoke's femur. The owner's wife was riding with him. She unsaddled the pony and shot it. She immobilized the fracture with a full length body splint, consisting of long willows bound in position with his bridle reins and latigo straps. She retrieved a



This case was a 17-year-old boy with an oblique fracture of the surgical neck. The fragments were fixed with a staple made from a horse-shoe nail. This picture was taken 25 years after operation. You will note the growth of the humerus and the condition of the nail.

dried cowhide from the top of a nearby roundup corral and towed the fellow six miles home at the end of her las-rope.

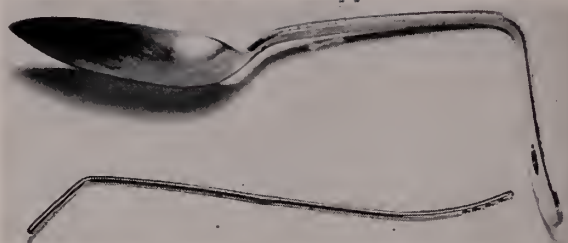
Treatment of these fractures presented no unusual difficulties as every ranch had well-equipped carpenter and blacksmith shops. Splints and traction frames could be made quickly and to exact measurement and design.

Anesthesia was our greatest problem. Nerve block and infiltration with Schleich's solution was used when possible. Schleich's solution was a very dilute solution of cocaine and morphine in a normal saline vehicle.

Chloroform was considered a safe anesthetic with pregnant women.

Ether anesthesia was a complicated process, requiring setting up the surgery, inducing the patient, prepping the patient, and then rescrubbing.

Normal saline solution, given by hypodermoclysis



I was on a week-end goose hunt on Snake River near the mouth of the Bruneau. Just after finishing the morning shoot, I was called to a near-by ranch. The patient, a middle-aged woman, was bleeding profusely from a submucous fibroid.

I designed a Sims speculum from a stirring spoon, a Burnay packer from the bail of a lard-pail, tore narrow strips from an old linen table-cloth for sponges and packing, added two pillow-slips for drapes, and boiled the set-up on the kitchen stove.

She was placed upon a table, in Sims position, and with a little care, I packed the uterus.

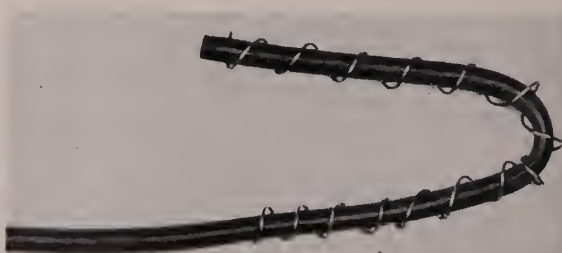
I then loaded her, mattress and all, in the back of a spring wagon and started the family for St. Alphonsus Hospital in Boise, with a note to Dr. McCalla.

I was back in my blind for the afternoon flight.

beneath the breasts and quadriceps muscles, was used extensively. Not to correct a fluid nor an electrolyte imbalance but to dilute the toxins and aid in their elimination.

Our wonder drug was oxygen anywhere. In 1904 a small oxygen generator came out, using fused sodium peroxide and water. The generation of nascent oxygen was automatically controlled by the consumption. The sodium peroxide was sold in small sealed cans, each capable of generating for two and one-half hours.

I recall one clever little gadget that I must mention. The native diphtheria bacillus, before it became so harassed by toxins and antitoxins, was one of the most virulent and most rapidly growing pathologic organisms on blood serum media. We



Hay-wire used to shape rubber tubing to permit siphoning fluids from any type of container available.

made use of the latter trait in diagnosing atypical cases, especially the laryngeal form. We carried blood culture media in little, square, flat boxes with a clip on the back. The culture media would be streaked with a throat smear and clipped inside the trouser band. A visible culture, after eight hours' incubation, was considered positive.



Plication Operation in Treatment of Small Bowel Obstruction*

ROBERT S. SMITH, M.D.

BOISE, IDA.

DESPITE good surgical technic and gentleness of visceral manipulation, peritoneal adhesions of a virulent nature, productive of recurrent small bowel obstruction, are prone to develop in an important group of abdominal cases. Amniotic fluid, digestive ferments, heparin and other substances have been introduced into the peritoneal cavity by various workers in an effort to prevent formation of postoperative adhesions but efforts along this line have been attended by very little success. An entirely new approach to the intestinal obstruction problem was first reported in 1937 by Thomas B. Noble, Jr.,¹ who suggested a technique of small bowel plication aimed at the deliberate production of non-obstructive adhesions.

According to Noble's technique, several operative steps must be carried out in order to deal effectively with peritoneal adhesions causing recurrent intestinal obstruction. In a case of chronic obstruction all small bowel adhesions must first be freed and any intestinal fistulae or perforations closed by suture. Severely damaged portions of the bowel are resected where necessary. Following these procedures the involved small bowel loops are plicated, being folded back and forth and sutured to each other in a grill-like arrangement. Adhesions form postoperatively between the loops of intestine which have been sutured together and also to the greater omentum and parietal peritoneum but in most cases the bowel functions perfectly and obstruction does not recur. Noble has now used the plication operation successfully in more than 300 cases, employing this technic in treatment of acute and subacute peritonitis as well as in the handling of cases of chronic intestinal obstruction due to peritoneal adhesions.^{2,3,4,5,6} Re-

cently Seabrook⁷ and Lord, Howes and Jolliffe⁸ have presented reports of their experiences with the plication operation. In general, the findings of these surgeons agree with those of Noble.

The chronic sufferer from effects of recurrent peritoneal adhesions is a pathetic individual. At best, this patient experiences a daily cramping discomfort in the abdomen which causes him to seek medical advice constantly and all too often his complaints are interpreted as being functional in nature. At worst, the patient must submit to multiple operations for relief of acute episodes of obstruction, with no prospect of complete or permanent cure. In the end, the severe case may be subjected to extensive bowel resection or develop various intestinal fistulae, on a spontaneous or operative basis, having deleterious effect on the body economy. Seabrook, and Lord and his associates have reported the grave systemic effects which can occur in cases of recurrent small bowel obstruction.

The intra-abdominal findings in cases with extreme adhesion-forming propensities are frequently quite remarkable, since their peritoneal adhesions are productive of very complex intestinal relationships. Such cases show loops of small bowel which are twisted, turned, kinked and bound together in a mass of adhesions. The adhesions themselves may be dense, membranous, or string-like in consistency. When operation achieves reorganization of the small bowel pattern in a case of severe abdominal adhesions, normal intestinal function is rapidly restored. The patient is indeed grateful for the relief from pain and the improvement in general nutrition which customarily follows small bowel plication.

Personal experience with the Noble operation in the treatment of five cases of recurrent intestinal adhesions is summarized in Table 1. As indicated in the table, all of these cases had severe adhesions in the lower abdomen; four showing pathologic conditions in the pelvis and one developing severe abdominal adhesions following appendectomy. Four patients were women. Three cases were operated upon in an interval following attacks of acute ob-

*Read before a meeting of the Boise Chapter of American College of Surgeons, Boise, Ida., Dec. 9, 1950.

1. Noble, T. B., Jr.: Plication of Small Intestine as Prophylaxis against Adhesions. *Am. J. Surg.*, 35:41-44, Jan., 1937.

2. Noble, T. B., Jr.: Plication of Small Intestine. *Am. J. Surg.*, 45:574-580, Sept., 1939.

3. Noble, T. B., Jr.: Place of Plication in Treatment of Peritonitis. *J. Internat. Coll. Surgeons*, 5:313-319, July-Aug., 1942.

4. Noble, T. B., Jr.: Perforating Wounds of Intestine; Satisfactory Method of Treatment for Wounds More Than 24 Hours Old. *Am. J. Surg.*, 62:50-58, Oct., 1943.

5. Noble, T. B., Jr.: Treatment of Peritonitis and Its Aftermath. Indianapolis, A. Vernon Grindle, 1945.

6. Noble, T. B., Jr.: Acute Peritonitis; Treatment of Pathologic Process and Its Immediate Aftermath; Further Experiences with Plication. *J. Internat. Coll. Surgeons*, 14:66-81, July, 1950.

7. Seabrook, Dean B.: Chronic and Recurrent Intestinal Obstruction. *West. J. Surg., Ob., and Gyn.*, 57:331-335, Aug., 1949.

8. Lord, Jere W., Jr., Howes, Edward L., Jolliffe, Norman: Surgical Management of Chronic Recurrent Obstruction Due to Adhesions. *Annals of Surgery*, V, 129: 315-322, March, 1949.

struction. In one case, plication of the lower ileum was carried out during a phase of acute pelvic inflammation, which was secondary to multiple operative procedures performed elsewhere. In another, plication of the terminal ileum was combined with elective abdominal hysterectomy. The operative summaries in Table 1 amply document the virulent recurrent character of the adhesions in these surgical patients. The first case in which the plication operation was used (A. M. C.) was in a state of complete invalidism after undergoing twelve different surgical procedures (fig. 1), and the operation was employed more or less as a last resort. The patient died of a late complication after having been completely relieved of symptoms for four months. The other four patients are all doing well at the present time.

Intra-abdominal manipulations necessary to prepare the small bowel for plication may be time consuming and shocking to the chronically ill patient. Actual plication of the intestinal loops can usually be accomplished fairly rapidly using standard suturing techniques. Every effort should be made to fortify the patient preoperatively and at the time of surgery against effects of blood loss and wound contamination by intestinal contents.

Since ileus usually develops following an extensive intestinal plication, and may persist for a week or more, it is good practice to pass a Miller-Abbott tube into the duodenum for prevention and control of postoperative distention. The roentgenogram of Case 3, shown in fig. 2, demonstrates the gas pattern characteristic of plicated small bowel in the early postoperative period. Incidentally, the return of normal intestinal function was unusually delayed in Case 3, and was not well established until the twelfth day following plication. Hypodermic administration of prostigmin (1:4000) and intravenous injection of 0.2 per cent potassium chloride in 5 per cent dextrose solution was found helpful in inciting effective peristalsis in this case.

The following presentation of the clinical course of patient A. M. C. is made in some detail, since it is believed that the fatal complication in this case is worthy of particular consideration.

Case 1. A. M. C., female, age 54. Patient was received by ambulance on June 7, 1949, from another community twelve days after she had undergone her ninth operation for abdominal adhesions. She appeared to be acutely obstructed but responded immediately to passage of a Miller-Abbott tube. After a week of intestinal suction, the tube was withdrawn. The obstruction recurred and an emergency enterostomy was necessitated. At operation about eight feet of the upper small intestine was found to be free of adhesions but the rest of the bowel was buried in a dense mass of adhesions in the pelvis and right side of the abdomen. The enterostomy tube was therefore inserted into the ileum in the left lower abdominal quadrant, just before the intestine passed into the mass of peritoneal adhesions. The patient was discharged from the hospital with the enterostomy tube in place and for four months managed very well,

gaining weight in spite of the fact that there was constant free drainage of intestinal contents from the enterostomy tube.

At this time it was reasoned that if the patient did well with an external small bowel fistula, she might do as well with an internal intestinal fistula. She was therefore brought back to the hospital and an anastomosis of ileum to the descending colon carried out. When the enterostomy tube was removed, however, the patient had difficulties of a somewhat different nature. She had cramping pains in the abdomen daily, and was practically confined to her house by the necessity of handling frequent loose bowel movements. In spite of all attempts at medical management, this diarrhea could not be relieved. The irritative effect of small bowel contents on the descending colon was demonstrated by the passage of large amounts of mucus from the rectum each day.

After about six months in this situation, it was decided to try to accomplish the solution of all of this patient's difficulties by radical surgical treatment. After preparation with sulfasuxidine, she was readmitted to the hospital. In one four-hour procedure, the ileocolostomy was dismantled, all adhesions of the small bowel freed, three feet of hopelessly damaged ileum resected and the small intestine plicated from the ligament of Treitz to the ileocecal valve. A generous T-shaped abdominal incision was employed and interrupted sutures of number 000 cotton on an atraumatic needle were used for the intestinal plication. The patient did very well following this radical surgery. Effective intestinal peristalsis was established after seven days and she was discharged from the hospital on the eighteenth postoperative day. She was a very much happier individual after this operative procedure. Her bowel function was normal and she had only occasional slight cramping sensations in her abdomen.

Four months after her Noble operation, this patient developed severe abdominal pain after taking a laxative, followed by enemas, in treatment of a cold. She was given morphine by her local physician but continued to have pain and began to vomit. She was brought to Boise on October 13, 1950, where information was given that her laxative had been a plain mineral oil and agar preparation. (Much later, it developed that her laxative had contained phenolphthalein.) On admission to St. Luke's Hospital the white blood count was 12,450, temperature 98.6°, pulse 82, blood pressure 160/90. She was complaining of pain in the right side of the abdomen but X-rays of the abdomen demonstrated a moderately dilated loop of small bowel in the left upper quadrant. The clinical picture was that of an early mechanical obstruction; but, because it was not believed that a plicated loop of intestine could suffer any serious involvement of its blood supply, and because the patient did not appear very ill on admission, it was decided that she could be safely observed. A Miller-Abbott tube was put down and intravenous fluids administered.

During the night following her admission to the hospital the patient's condition appeared improved and her intestinal suction worked well. Early the following morning, however, she showed signs of circulatory collapse. She was transfused and taken to surgery. As the anesthetic was started, the patient went into surgical shock. With the administration of blood under pressure and the intravenous injection of suprarenal cortical extract, her condition improved sufficiently, however, to allow quick opening of her old midline incision and exploration of the abdomen. An accumulation of about 1000 cc. of turbid fluid was evacuated from the left upper quadrant and loops of jejunum were found to be markedly distended and covered with exudate.

The cause of the intestinal obstruction was readily found. The omentum had become bound to the descending colon at the site of the previous ileocolostomy, and had produced a marked compression of the jejun-

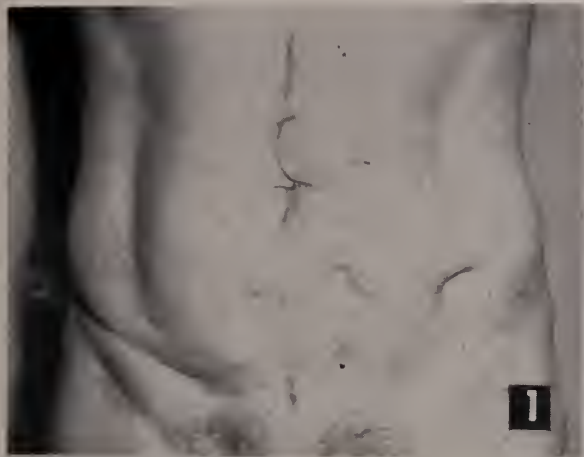
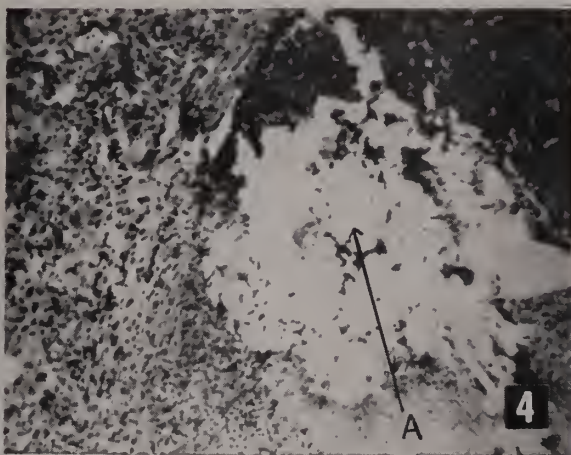
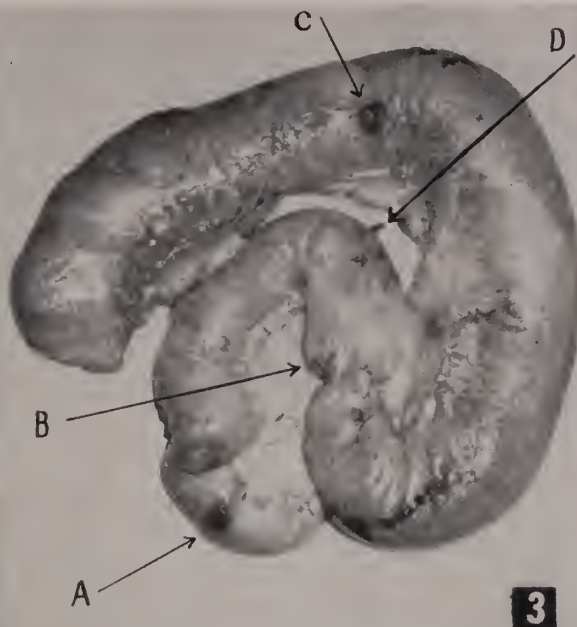


Fig. 1. Case 1. Photograph of abdomen made 9-24-50 illustrates multiplicity of previous operative procedures, T-shaped scar of operation on 6-14-50 for dismantling of ileocolostomy and small bowel plication.

Fig. 2. Case 3. Roentgenogram on third day after plication operation showing characteristic postoperative ileus, Miller-Abbott tube in duodenum.

Fig. 3. Case 1. Gross appearance of jejunum at au-

tom at a point about 20 inches from the ligament of Treitz. Distended loops of jejunum above this obstruction were not adherent to each other and ecchymotic areas were seen on the bowel which were taken to be points at which previous plicating sutures had avulsed. Although it was evident that the loops of obstructed jejunum had literally blown apart, hurried examination failed to reveal any actual perforation of the bowel at any point and there were no areas of gangrene. The omental band causing the jejunum obstruction was ligated and divided; but further operative manipulations were considered inadvisable in view of the critical general condition of the patient. Penrose drains were inserted into the left upper abdominal quadrant through a stab wound and the laparotomy incision rapidly closed.



topsy: A. Hemorrhagic area indicates site of avulsion of cotton suture. B. Intestinal constriction, with localized ecchymosis, marks point of obstruction, by omental band. C. Perforation of bowel. D. Cotton suture attached to bowel, showing avulsed free end.

Fig. 4. Case 1. Photomicrograph of section from wall of obstructed jejunum, showing cotton suture (A), marked cellular reaction of inflammatory type in surrounding tissues.

The patient failed during the night, and expired the following morning. At autopsy, the cause of death could be decided without much difficulty, when the findings illustrated in fig. 3 were considered. A very small leak was found in the jejunum where one of the cotton sutures used for the patient's previous intestinal plication had pulled out. Death had occurred as a result of acute peritonitis, complicating a high intestinal obstruction.

DISCUSSION

This fatality brings up some interesting questions concerning the proper suturing technic for the plication operation. In his writings, Noble has stated that the intestine should be plicated with running

sutures of fine catgut, plain or chromic, lightly placed at the mesenteric border of the bowel. Lord and his associates⁹ have done twelve plication operations and prefer interrupted cotton or silk sutures when plicating the bowel. In a personal communication,¹⁰ Noble has suggested that foreign body reaction around a cotton knot may cause spot softening in the intestine which will result in a blowout if distention occurs. In fig. 4, the photomicrograph shows a cotton suture taken for examination from the wall of the obstructed jejunum of the case reported above and demonstrates very well the type of foreign body reaction which may occur around a plicating suture of cotton.

In the series of cases presented in Table 1, interrupted number 000 cotton sutures were used for plication in the first three, interrupted number 000 chromic catgut sutures in the fourth, and continuous sutures of number 000 chromic catgut in the fifth. It is believed that a running suture of fine catgut will be favored when plication operations are performed in the future, since it would appear that this technique does have some definite advantages over the use of interrupted cotton sutures. Continuous sutures of catgut should incite adhesions between loops of bowel on a broad base, and yet these sutures can be expected to be completely absorbed in a relatively short period of time. It is obvious that all plicating sutures should be placed as lightly as possible, at the mesenteric margin of the intestine or in the mesentery itself immediately adjacent to the bowel.

In the fatal complication of Case 1, a combination of circumstances developed which were more or less accidental and unpreventable. No way of controlling adhesions of the greater omentum has yet been devised, short of amputation of the membrane. In this case the omentum apparently became fixed to the colon early in the postoperative period, lying across the jejunum in such a way that a condition of partial compression of the bowel was produced. This partial compression progressed to complete obstruction after the intestines had been irritated by a phenolphthalein-containing laxative, and multiple enemas. Since the jejunal loops were not adherent together on a broad base, the small points of contact produced by the cotton sutures could not be maintained when the bowel became distended.

Noble's theory that foreign body reaction around a cotton knot tends to cause spot softening in the bowel wall seems to be supported by the autopsy findings in this case. Had the surgeon not been confident that strangulation or localized necrosis could not occur in a plicated bowel, the abdomen

TABLE 1
CASES TREATED BY PLICATION OPERATION

CASE 1. A. M. C., 54, F.

Previous Treatment

1. Bilateral salpingo-oophorectomy at age 17.
2. Eight operations for intestinal obstruction 1940 to 1949.
3. Lysis of adhesions 5-26-49.
4. Enterostomy 6-18-49.
5. Ileocolostomy 10-26-49.

Operation

6-14-50 Dismantling of ileocolostomy, resection of ileum, plication of entire small bowel.

CASE 2. C. W., 35, F.

Previous Treatment

1. Appendectomy 1936.
2. Lysis of abdominal adhesions, and resection of ovarian cyst 1938.
3. Cecostomy and lysis of adhesions 1948.
4. Lysis of adhesions 1949.

Operation

6-19-50 Plication of entire small bowel.

CASE 3. D. B. C., 48, M.

Previous Treatment

1. Appendectomy 1942.
2. Lysis of adhesions 1944.
3. Intestinal obstruction relieved by Miller-Abbott tube 1946.

Operation

7-1-50 Plication of entire small bowel.

CASE 4. L. H., 38, F.

Previous Treatment

1. Total hysterectomy, and right salpingectomy 7-29-49 (ureterovaginal fistula, bilateral).
2. Uretero-vesical anastomosis, left 9-7-49.
3. Uretero-vesical anastomosis, right 10-5-49.
4. Nephrostomy, right 4-6-50.
5. Nephrectomy, right 7-10-50

Operation

8-25-50 Drainage of pelvic abscess, plication of ileum (lower nine feet).

CASE 5. T. H., 42, F.

Previous Treatment

1. Bilateral salpingectomy, appendectomy, resection of ovarian cysts, and lysis of pelvic adhesions 1-30-47.

Operation

12-7-50 Total Hysterectomy, plication of ileum (terminal three feet).

would have been explored earlier. The possibility of a perforation was not considered before surgery, and at operation the small leak in the bowel was evidently sealed off by fibrin and quiescent.

There would seem to be a definite place for localized or segmental plication of the small bowel, as illustrated by Case 4 and 5 (Table 1). Unless intestinal loops are substantially denuded of peritoneum, it would appear meddlesome to suture them together. In the fatal case reported, the difficulty actually developed in a portion of the upper bowel which had been free of serious adhesions at the time of plication. Since most adhesions of virulent type develop in the pelvis and lower abdomen, greatest field for the plication technic may be found in that region; and in the lower abdomen a segmental or limited plication may accomplish a great deal.

While Lord⁹ has indicated that his only failures following the Noble operation have been either in

9. Lord, Jere W.: Personal Communication.

10. Noble, T. B., Jr.: Personal Communication.

cases of psychosomatic defect or incomplete plication, Seabrook¹¹ has implied that some cases are simply too far advanced to be cured by any operative treatment. At any rate, the plication operation does appear, at the present time, to be a notable contribution to the treatment of recurrent intestinal obstruction.

11. Seabrook, Dean B.: Personal Communication.

A word of caution concerning management of the plication patient after operation seems appropriate. It is believed that it is the duty of any surgeon performing an intestinal plication to warn his patient against taking any strong laxative by mouth. It is also the surgeon's duty to operate without delay or hesitation when a plication case returns complaining of severe recurrent abdominal pain.

Emergency Surgery and Emergency Treatment of Eye Burns*

A. C. JONES, M.D.
BOISE, IDA.

ALMOST DAILY, patients are admitted to one of the hospitals following an auto wreck. Usually several people have been cut, bruised and broken. The facial lacerations produce quite a number of complicated surgical questions.

Great care should be taken in saving every vestige of skin and tissue. Before grabbing sutures and needle holders, your surgical reconstruction should be visualized and a temporary outline should be reconstructed on the patient's face. Sometimes the tissues are so thoroughly mixed that it is very easy to make a mistake in the proper rearrangement of small pieces of skin. This applies not only to the face, but also to the lids, the lips and the nose. No skin should be cut off and thrown away, even though the pedicle to which it is hanging may make it look non-viable. Sometimes the entire piece has to be severed. After the fat and subcutaneous tissue are removed, the piece can be used as a full thickness graft. It should be carefully sutured into place, using 6-0 black silk, and a pressure dressing applied.

An angular cut in the eyelids, when properly sutured, can prevent marked and noticeable deformities. A careful approximation of the margin of the eyelids will tend to prevent this angular scar formation. Occasionally it is necessary to use supporting sutures throughout the subcutaneous skin and tarsus.

In suturing skin wounds, subcutaneous and muscular tissues are approximated with 4-0 chromic catgut on a swedged needle. This careful approximation before the skin sutures are placed prevents wide separation of the scar tissue and gives a thin line scar instead of a wide flat scar. The skin is then closed with 6-0 silk sutures. The 6-0 silk suture on the swedged needle does not leave any

suture hole scars. These sutures should be removed in three or four days. If larger silk is used the sutures should be removed in two days.

The entire face does not need to be swathed in bandages. I think the heavy dressing tends to produce wound infections. We first apply tincture of benzoin along margin of wound and then saturate small wisps of cotton with the tincture of benzoin to cover the wound. If the cut is where the movement of the face might possibly separate the suture line, collodion-saturated gauze strips placed at right angles to the wound will prevent stress and strain on the wound when eating or talking.

If we are working with a local anesthetic, we use the 30-gauge needle for the infiltration of our novocaine. The 30-gauge needle, when inserted around the face, eyelids, lips or nose, causes almost no pain and facial wounds in children can be easily sutured without giving them a general anesthetic.

Nasal fractures should be reduced before the face and adjacent tissues become so swollen that they cause marked distortion. Local anesthesia is all that is necessary in many nasal fractures. The orbital, the infra-orbital, and the anterior and posterior ethmoid nerves can be blocked and the over-lying nasal tissue can be infiltrated. Interior of the nose is swabbed with 10 per cent cocaine and adrenalin. I have used this procedure on many football nasal fractures. After the fracture has been reduced, vaseline gauze is firmly packed within the nose. The tin can splint, which is quite pliable, is molded into place over the fractured nose and fastened down with strips of adhesive.

For the past year I have been using light gauze strips impregnated with quick-drying plaster which can be molded into place before it sets. This is left on until the nasal swelling has subsided and the plaster cast becomes mobile. Generally, about five

* Read before a meeting of the Boise Chapter of American College of Surgeons, Boise, Idaho., Dec. 9, 1950.

days is the length of time the plaster cast is left on the face.

No bleeding ear canal should be irrigated because of the danger of setting up meningitis. Most jaw fractures can be approximated and wired in place by a dentist. In scalp wounds the head should be shaved for a wide margin on each side of the cut.

EYE BURNS

The care of eye burns has been revolutionized by the use of hydrosulphosol. Hedwig Kuhn of Hammond, Ind., and A. E. Cruthirds of Phoenix, Ariz., have written several papers on care of eye burns and generalized burns. Quoting from Dr.

Cruthirds' paper, "This use of sulfhydryl, as contained in products which are identified by the trademark *hydrosulphosol*, was prompted by its successful application in hundreds of cases of major eye burns. Two doctors alone have each treated more than one thousand such injuries. Clinical results observed in treatment of major chemical or thermal eye burns or both have been covered in a series of nine published reports. However, we wish again to emphasize that, when this medication is used to treat new eye burns, the development of scars, adhesions and other ocular complication can be almost entirely avoided."

Local Anesthesia in Gynecologic Surgery*

HAROLD E. DEDMAN, M.D.

BOISE, IDA.

PRACTICAL USE of local anesthesia became possible 90 years ago with the discovery of cocaine. Forty-five years ago the discovery of novocaine by Einhorn made possible the performance of extensive surgical operations under local anesthesia with safety. Within a few years the use of local anesthesia became widespread in Europe. Professor Heinrich Braun of Zwickau, Germany, was among the first to put it to use on a large scale. His book, *Local Anesthesia*, first translated by Shields and published in this country in 1914, gave great impetus to the widespread use of this method in general surgery. In his text, he laments the relatively slow progress of local anesthesia in the field of gynecology. His teachings of its use in vagino-plastic surgery are sound today. They are little changed in practice but suffer from atrophy of disuse.

Continued slow progress in use of local anesthesia is influenced by teaching methods which, in view of the progress made in other methods of anesthesia during the past two decades, is readily understandable. Because of its nature, local anesthesia is necessarily the surgeon's anesthesia, to learn, to practice and to teach. Information on the subject is readily available on searching and opportunity for its practice frequently appears.

There are a number of reasons for advocating use of this method of anesthesia in gynecologic surgery. 1. Use of a drug of minimal toxicity, with minimal disturbance of liver function, body chemistry and fluid balance. 2. Elimination of known hazards of general anesthetics such as the always

unknown anesthetic risk to life, per se. 3. Diminished after-effects such as nausea and gaseous distention. 4. No failures of anesthesia, absence of disturbances of blood pressure, postanesthetic headaches, back and leg pains and paresthesias, in comparison to spinal anesthesia. 5. Expedition of the operation because of diminished bleeding. 6. Appeal to the patient. 7. Increased range of operability in aged and ill patients.

Contra-indications for surgery are diminished by use of local anesthesia. Old age, with its many degenerative implications, is rarely if ever a contra-indication to pelvic surgery, if the patient is properly prepared physiologically and psychologically for the procedure. Too frequently, we still see patients who for many years have lived in misery with the idea that nothing could be done for them because of the dangers of anesthesia.

Preparation of the patient for operation begins in the office where sometimes more than just casual reassurance is needed. It is frequently well (even necessary) to spend a little extra time with a worried patient, and perhaps members of the family, in order to give them added confidence in the whole procedure. This may make a great deal of difference in the amount of rest the patient gets between the time of scheduling the operation and the time of going to the hospital. All patients are encouraged to remain normally active and to eat as usual up to the time of entering the hospital.

On the evening preceding operation the usual preparation of the skin is followed by a cleansing enema and saline vaginal douche. At bedtime a vaginal instillation of Merthiolate in glycerine, drachms two, is given. At the same time, in order

* Read before a meeting of the Boise Chapter of American College of Surgeons, Boise, Idaho, Dec. 9, 1950.

to insure rest, phenobarbital or nembutal is given in appropriate dosage. Occasionally additional somnifacient during the night is indicated. On the morning of operation the enema and vaginal instillation are repeated. Two hours before operation seconal or nembutal is given, followed in one hour by morphine and scopolamine in an amount calculated to insure sleep and amnesia. This combination of drugs, which may be supplemented in surgery if indicated, overcomes anxiety and makes tolerable a more or less prolonged period in the lithotomy position.

The patient is placed on the operating table with the legs in leg holders of the type wherein the legs are suspended by tapes about the feet and ankles. Perineal and vaginal scrubbing with green soap solution is followed by thorough rinsing with warm water, and the application of aqueous solution of zephiran to the parts. The use of a tincture as a skin and mucous membrane preparation is disturbing to the narcotized patient. Aqueous solutions have proved to be equally effective.

The technic of infiltration follows the simple plan of injecting the solution into the areas required to prevent pain. It must be remembered that, to be effective, the anesthetic solution must be injected immediately subcuticularly or submucosally with the initial insertion of the needle. A small, sharp 24- or 25-gauge needle is used for the initial wheals. From this point on a 22-gauge, $2\frac{1}{2}$ - or 3-inch needle is most convenient for the deeper injection. Details of the technic are to be found in a number of texts. One-half of 1 per cent solution of procaine is used, although one-fourth of 1 per cent is effective if a little more time is allowed for anesthetic effect. We have never found it necessary to use more than five ounces of solution in the most extensive vaginal procedures. This amount is, of course, far below the point of worry so far as toxicity is concerned.

The entire procedure of injection requires not more than five minutes. By the time it is finished a vaginal hysterectomy with complete anterior and posterior repair can be started. It is well to mention here that, with this type of anesthesia, the Mayo operation or the clamp method of the Joseph Price hospital are not applicable because of the strong type of traction required. A clamp, cut and ligate operation, working upward from the cervix, is the operation of choice.

In the performance of vaginal hysterectomy under local anesthesia, it must be admitted that in the more difficult cases, wherein the indications for this operation may have been stretched a bit, there may be evidence of pain because of strong traction

placed upon the round and infundibulo-pelvic ligaments. This may be overcome by relaxation of traction and injection of more anesthetic solution into the tissues involved. In the occasional case, where evidence of such pain is marked, there may be reason to give the patient a very short inhalation or intravenous anesthetic. Need for this measure will be so brief as to cause no worry so far as the welfare of the patient is concerned. In the properly prepared patient there will be no memory of pain nor of anesthetic. The important point to realize in regard to this situation is that such supplemental anesthesia is never necessary in the case of aged patients where there might be the most concern. These are invariably the patients with lesions so well exposed that no strong traction is called for. Any operation needed can be completed under local anesthesia alone.

These impressions on the subject of local anesthesia are based upon experience of more than twenty years. Three hundred twenty-two cases done over the past six calendar years were reviewed. Vaginal hysterectomy has been mentioned because it is typical of the more extensive procedures which may be accomplished with the method. Incidentally, it is recorded as the operation most frequently performed. Anterior and posterior colporrhaphies, Manchester operations, excision of cervix stumps, repair of enteroceles, correction of vaginal atresias, colpocleisis, repair of vesico-vaginal fistulae and vulvectomy have all been performed. In many cases, vagino-plastic procedures were performed under local followed by laparotomy under general anesthesia. This materially shortened the latter. On a few occasions I have performed total abdominal hysterectomy under local anesthesia, each time with satisfaction. In addition to the above listed operations, numerous cervical dilatations, curettages, conizations and trachelorrhaphies have been done. There has been no mortality and morbidity has been rare. In no case has it been related to anesthesia. Average age of patients operated upon was 51 years, the youngest being 19 and the eldest 86 years of age.

In conclusion I wish to say that, in spite of now having available most competent and complete anesthesia services, I have no intention of abandoning use of local anesthesia in numerous selected cases. Particularly is its use indicated in hospitals not having anesthesia services in charge of trained anesthesiologists. Its over-all safety, the increased range of operability permitted, the blood saved and the immediate fine post-operative condition of the patients make it the anesthetic of choice.

Arterio-Venous Aneurysm of the Foot Following Plantar Fasciotomy*

J. J. COUGHLIN, M.D.

BOISE, IDA.

THIS is a case presentation of a complication following a well-known and accepted orthopedic procedure. It concerns a ten-year-old boy who presented himself for treatment of recurrent bilateral club foot deformity.

His history revealed that he was treated in another city with the application of corrective plaster of paris casts to both feet and legs. This treatment was instituted at the age of three weeks and con-



Fig. 1

tinued until he was three years of age. At the age of five years there was a recurrence for which further casting was performed.

On our initial examination, the patient revealed typical components of a club foot deformity; tightening or contracture of the heel cord resulting in a plantar flexion deformity plus varus of the heel and forefoot adduction. It was felt that further casting would be ineffective and it was decided that surgical treatment was indicated. A tendo-achilles lengthening and plantar fasciotomy was performed on both feet. The tendo-achilles was exposed and lengthened in a Z fashion. The plantar fasciotomy was performed by means of a sharp-pointed blade. The foot was dorsiflexed to put the plantar fascia bands on stretch. The scalpel was then drawn transversely in a sawing movement to sever the contracted bands.

The patient had an uneventful convalescence and

14 days after surgery the bilateral short leg casts, which had been applied postoperatively, were removed. The operative sites were well healed. Short leg braces were applied to prevent further recurrence of deformities.

Approximately eight weeks after surgery the patient was seen in our office. He complained of a painful swollen area over the medial plantar surface of the right foot, immediately underlying the site of the plantar fasciotomy. Both feet exhibited the same skin temperature on palpation and no cyanosis or color change was evident in the right foot. On further examination I found that a pulsation was present in this swollen area. On auscultation a very definite bruit could be heard. Figure 1 shows a profile view of the plantar surface of the right foot exhibiting the enlargement due to the swelling.

The patient was hospitalized immediately. The radiologist reported normal heart contour and no disease of lungs. The child was then examined by a pediatrician who found no clinical evidence of heart disease. The patient was prepared for surgical exploration of the mass.

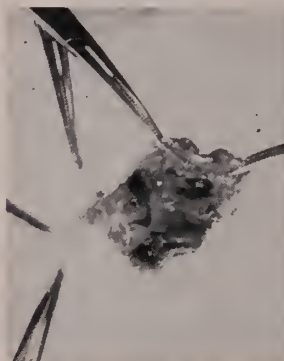


Fig. 2

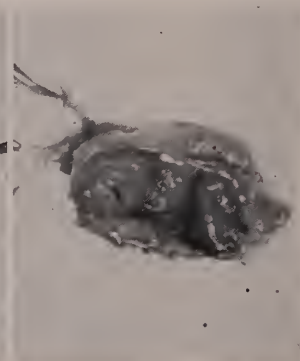


Fig. 3

Under general anesthesia, a longitudinal incision was made over the swollen mass on the right foot. A bluish-colored mass about the size of a walnut was exposed. On further dissection, this mass was isolated and on the dorsal surface was found to communicate proximally and distally with a vein and artery. These vessels were isolated both proximally and distally, clamped separately, ligated and severed and the mass was removed. The operative site healed uneventfully. Microscopic examination of the dilated structure excised was interpreted by the pathologist as being dilated vein tissue. Figures

* Read before a meeting of the Boise Chapter of American College of Surgeons, Boise, Idaho., Dec. 9, 1950.

2 and 3 show the mass removed. It had been opened to visualize its interior.

The patient was seen one month following this surgical procedure, at which time he had no complaints referable to this previously painful area. The circulation in both feet appeared equal. Also, he appeared to be maintaining the correction of the equinus and forefoot adduction deformities of both feet.

It is my impression that this vascular mass rep-

resents an arterio-venous aneurysm of a branch of the medial plantar artery and vein which were inadvertently severed at the time of the plantar fasciotomy. I have questioned my orthopedic colleagues and reviewed the literature and have been unable to find an account of such a complication. I have presented this case report feeling that a complication of this type, which is apparently rare in occurrence yet secondary to a rather commonly performed operation, merits mentioning.

Hiatus Hernia and Gastrointestinal Diverticulosis*

ALFRED M. POPMA, M.D., AND ALFRED M. STONE, M.D.

BOISE, IDA.

UNTIL approximately two decades ago the incidence of reported diaphragmatic hernia was relatively low. Few cases were recognized and discovery of such an entity was considered as more or less of a rarity. It was of sufficient news interest to warrant reporting in medical meetings and in the literature. However, increased awareness on the part of the examining physician associated with improved technics of examination have brought to light a great number of instances of diaphragmatic hernia. Literature of the past 15 years contains numerous articles on this subject, to the point that very little original can be added to it. No longer need the patient with vague epigastric or precordial distress be immediately labeled as coronary disease or biliary tract disease. Careful and thorough clinical and radiological examination has definitely reduced the number of so-called heart cases and correctly classified them as hiatus hernia. The clinical syndrome, the diagnostic approach and the therapeutic management are now well understood and carried out.

Somewhat less well recognized and understood, therefore, probably not quite as well managed, is the general problem of diverticulosis of the small intestine and colon. These entities have been recognized with considerably less enthusiasm for many years but often, because of technical surgical difficulties or lack of interest or understanding, the patient with this problem is frequently not given the maximum opportunity of therapeutic consideration. The discomfort and disability produced by these lesions is real and usually not of short duration or self-limited in extent.

The purpose of this presentation is to call attention to the apparent relationship existing between

gastrointestinal tract diverticulosis and hiatus hernia. An attempt will be made to show that the patient with hiatus hernia frequently has diverticulosis of the gastrointestinal tract and that treatment for the hiatus hernia alone may not entirely relieve his symptoms. We shall further show that these syndromes are particularly prone to occur in the aging and the aged and that, therefore, the practitioner of geriatrics must necessarily include certain considerations which are not always present when treating the younger group. Multiplicity of pathological entities is increasingly apparent with increasing age and, while some lesions may be silent and produce no symptoms, there are many instances where each lesion gives signs and symptoms which may blend together to obscure any single condition.

Approximately two years ago we became impressed with the fact that discovery of a hiatus hernia was an indication to initiate search for diverticulosis of the duodenum, jejunum or colon. Since then approximately 3,000 gastrointestinal examinations have been done. Sixty patients were found to have hiatus hernia. These varied from small herniations of 2 cm. in diameter to massive lesions up to 16 cm. in diameter. Because of the variation in surgical treatment to eradicate this lesion, an attempt was always made to determine whether or not there was a congenitally short esophagus. The smaller herniations have almost invariably been found to be associated with a congenitally short esophagus.

Frequently it has been difficult to differentiate a small hiatus hernia from a phrenic ampulla. The criteria which we have laid down for differentiation is the presence or absence of gastric rugae in the dilated area at or above the hiatus. In some instances, extreme Trendelenberg position was necessary to satisfactorily visualize the true character of the abnormality.

* From the Department of Radiology, St. Luke's Hospital, Boise, Idaho. Read before a meeting of the Boise Chapter of American College of Surgeons, Boise, Idaho, Dec. 9, 1950.

Within the group of 60 patients in whom there were demonstrated hiatus herniations there were 28 individuals who were also found to have diverticulae of the duodenum, jejunum or colon. In some instances these were solitary; in others they were multiple and widespread. Since all of these patients were referred for radiological examination because of gastrointestinal complaints, it soon became apparent that it was going to be difficult to pin down the symptoms as being caused by the hiatus hernia alone and ignore the diverticulosis, or vice versa, to cast aside the significance of the hernia and direct all therapy toward the diverticulosis. To a large extent this has been a problem for the internist and the surgeon, who have found satisfactory solutions in many instances.

The age incidence of our group of cases is of interest. A relatively small number of patients having this combination of entities were in the middle age group. By far the greater majority were found to be in their sixth, seventh and eighth decades of life. We feel, therefore, that with increasing longevity there is to be expected an increasing incidence of combined occurrence of hiatus hernia and gastrointestinal diverticulosis. It is important, there-

fore, for the physician treating the aged and for the radiologist examining the aged and the aging, to recognize the co-existence of these conditions.

Occurrence of these combinations of lesions in the older groups of patients suggest a possible etiology. There is presented the hypothesis that many of these conditions occur as a result of aging and generalized deterioration and weakening of body tissues, particularly the muscle fibers of the diaphragm and intestinal walls.

The therapeutic approach to this problem is beyond the scope of this discussion. It has merely been the purpose of this presentation to call attention of the physician to the facts that there appears to be a definite co-existence of hiatus hernia and gastrointestinal diverticulosis; that these are found with increasing frequency in people beyond middle age, particularly in the sixth, seventh and eighth decades of life; that, with an increasing longevity of our population generally, it can be predicted that there will be an increase in recognition of this syndrome, and that therapeutic management is a problem for joint consideration and consultation between the internist and surgeon.

Discussions of the Papers Presented at the Boise Meeting of the Southern Idaho Chapter of the American College of Surgeons

C. S. STONE, JR., M.D.
SEATTLE, WASH.

MR. PRESIDENT, Fellows of the local chapter of the American College of Surgeons, and guests: First, I want to say that it is a very real pleasure and a privilege to have this opportunity of being with you and discussing the papers of this program on the occasion of your first meeting. I would like also to congratulate you all on the occasion of this first meeting of your local chapter, for I am sure you will find both pleasure and benefit through this body. The organization locally of Fellows of the American College of Surgeons sets up a local organization which will bring each of you into closer touch with the great work that the college is doing. It will help to build a stronger and better organization. It will bring you into closer touch with and exert your influence to greater advantage on the tremendous problems of the day, as well as to provide the means for a splendid and instructive scientific program such as we are having here today. I am particularly pleased and honored to be your guest at this meeting and to discuss the papers on this program. Some of them deal with

specialized subjects that I am not competent to discuss; however, I am delighted to be here and to hear your program and to discuss those papers to which I can add something.

I particularly enjoyed Dr. Kellogg's paper. I like reminiscences and especially those that deal with subjects as interesting to us as those covered in Dr. Kellogg's paper and particularly when they are so attractively told. I am aware of the fine work Dr. Kellogg did here many years ago, his foresightedness and his resourcefulness, particularly in the treatment of fractures. I think it does all of us good to frequently stop and look back over the road we have traveled in the memory of those who are still with us, for it helps to build background for all of us and it keeps fresh in our minds the great strides that have been made in medicine in recent years and the rapidity with which developments have come. Dr. Kellogg's comments about the early days in southern Idaho remind me very much of the stories I have heard my father tell about his early days in northern Idaho where he lo-

cated in the middle '80's. While he did not have to travel the great distances covered by Dr. Kellogg, many of his trips were rigorous, particularly in the wintertime, when he had to cross the mountains through heavy snows. The problems of such a practice called for courage, resourcefulness and ingenuity just as they did in Dr. Kellogg's experience.

Dr. Jones' paper on emergency surgery is timely and replete with important messages to the doctor who first sees a patient who has suffered wounds about the face. I have little to add but I think it is proper to re-emphasize the points that he made. Careful and gentle management of wounds of the face, proper debridement and careful approximation of the tissues are essential if one is to obtain good healing. Injuries of the bony structures of the face must be recognized promptly and treated promptly. Depressed fractures of the maxilla particularly can be relatively easily reduced at the time of injury, whereas, if they are not recognized or not treated but allowed to heal in poor position, deformities of the face are prone to follow and the secondary repair is a much more difficult problem in many instances than elevation of the fracture at the time of the accident would have been. Another thing to be remembered is that traumatic disfigurement of the face all too often leads to emotional disturbances on the part of the patient in years to follow. This is particularly true and well recognized in patients with congenital deformities, but it is equally true, I think, of acquired deformities and often leads to serious embarrassment to the patient, sometimes interfering with ability to make a living. The essence of the message brought to us by Dr. Jones is all-important and can certainly bear repeating. Careful and accurate diagnosis to start with, extreme care and gentleness in the handling of tissues, careful approximation of skin edges, conservation of tissue and avoidance of disfiguring scars and deformity are all important if nice and satisfactory results are to be obtained. In this day and age of fast automobiles and multiple accidents, all of us should be constantly on the alert in dealing with traumatic lesions about the face.

Dr. Coughlin's paper on arteriovenous aneurysm of the foot following a plantar fasciotomy is most interesting. I have never heard of or seen such a complication develop after fasciotomy and I gather from conversation with some of my orthopedic friends that it is an extraordinarily rare complication. Dr. Coughlin is to be complimented on his prompt recognition of the lesion as well as his foresight and good judgment in not incising the mass when it was noted. Treatment as carried out by Dr. Coughlin, of course, is the ideal treatment for arteriovenous fistula, namely, four-point ligation with excision of the mass including the involved

vessels. This is accepted, I think, by everyone as an ideal procedure except in those instances where very major vessels are involved and the distal tissues would be jeopardized by removal if adequate collateral circulation were not present. In some cases it is possible to do other procedures. When dealing with larger vessels, it is frequently feasible to use blood vessel grafts which are, in the main, rather satisfactory. Certainly in the case presented here today, four-point ligation was the ideal procedure and led to very satisfactory recovery.

In any discussion of arteriovenous fistula, it is well to remember the vast experience that developed in this connection during World War II. It is especially pertinent at this time, with the war in Korea and the unsettled international condition of the moment, for who knows when we may again be faced with the tremendous volume of vascular injuries that confronted us during World War II? Dan Elkin, professor of surgery at Emory Medical School in Atlanta, Ga., was, during the war, chief of surgery at the general hospital at White Sulphur Springs. This, as you know, was a vascular center and here it was that Dr. Elkin developed probably the greatest individual experience with injuries to the blood vessels and aneurysm that any American surgeon has ever enjoyed. His contributions to this subject have been many and should contribute greatly to the pattern for management of vascular injuries in the future.

Dr. Dedman's paper on local anesthesia in gynecological surgery is certainly interesting. I can't say much about local anesthesia in gynecological surgery, for, though I do a good bit of gynecological surgery, I have had little or no experience with local anesthesia in this field. However, I certainly agree with his reasons for advocating the use of a local anesthesia. Certainly it is a drug of minimal toxicity, it causes minimal disturbance to the patient, and eliminates certain hazards that are met with in general anesthesia. It is certainly a less hazardous anesthesia than spinal and I am quite sure that the effectiveness of local anesthesia in gynecological surgery is a measure of the ability of the surgeon with regard to administration of the anesthetic. I am glad to see that Dr. Dedman administers his own local anesthesia and that he proposes to continue this practice. In this modern day of anesthesia where so many doctors are specializing in anesthesia, we all tend to turn over to them not only the choice of anesthesia but its administration. While I am sure there are many advantages in such a procedure, I think it is well for the surgeon to retain the ability to administer his own local anesthesia. The developments in anesthesia, however, have certainly been remarkable and borne great fruit. The efforts of the interested specialist have

brought rapid advances in anesthesia and I think these developments contributed tremendously to the increased scope of surgery that is being done, not only in the extent of surgical procedures carried out but the ease with which poor-risk patients are now brought through surgery uneventfully. In many centers, I know that the anesthesiologist is relying more and more on local anesthesia used as paravertebral block and the combination of such a local anesthesia with a minimal amount of general, either inhalation or intravenous, anesthesia has been a happy combination. It is timely, I'm sure, to have Dr. Dedman focus our attention upon use of local anesthesia alone or supplemented with a small amount of general, for it is in so many instances a thoroughly satisfactory, safe anesthetic and I am sure we could all profit by using it more often.

The paper on hiatus hernia in gastro-intestinal diverticulosis by Dr. Popma and Dr. Stone is interesting. Dr. Popma's hypothesis that these two conditions occur as a result of aging and generalized deterioration and weakening of the body tissues, particularly the muscle fibers of the diaphragm and the intestinal wall, seems to me to be thoroughly sound. Certainly the incidence of the acquired hiatus hernia increases with age and more certainly the incidence of diverticulosis of the gastro-intestinal tract increases with advancing years. It has been roughly estimated, I believe, that somewhere in excess of 25 per cent of people beyond 50 years of age have diverticulosis of the gastro-intestinal tract. Some estimates have been even higher for patients of this age group, but at any rate, the incidence is certainly in excess of the incidence of diaphragmatic hernia. I quite agree with Dr. Popma that the discovery of either lesion should make one particularly curious about the other. The role of the roentgenologist in carefully studying the entire gastro-intestinal tract in the search for organic disease which may be the cause of the symptoms presented by the patient cannot be overemphasized. The symptoms developing as a result of diverticulosis or diaphragmatic hernia may be relatively simple, vague and not alarming. Careful and complete examination of the gastro-intestinal tract is important, particularly in this group of people with relatively minor symptoms, in order to find disease that may be present. It is not only important to find all the lesions that may be there, as suggested by Dr. Popma, but it is important that patients with symptoms which are relatively mild be studied, for it is only in this way that earlier diagnosis of malignancy of the gastro-intestinal tract will be accomplished. Dr. Popma has not gone into the therapeutic management of problems of the gastro-intestinal tract except to say that it is a problem for the joint consideration and consultation

between the internist and the surgeon. I think it is pertinent to add that it is also the responsibility of the internist, the surgeon, and the radiologist to examine patients with minor gastro-intestinal symptoms, particularly patients of the middle and upper age groups and patients who have had blood in the stools, not only with extreme care but repeatedly—if necessary, in order to establish a positive diagnosis. It must be remembered that diverticulum of the tract is most common in the same age group in which malignancy is most frequently seen and that early symptoms of carcinoma may be identical with those of diverticulitis as well as the fact that late symptoms of cancer may also be identical with the symptoms of complicated diverticulitis. It will frequently require the greatest efforts on the part of the internist, the surgeon, and the roentgenologist to make an accurate differential diagnosis and frequently it will only be made at the time of surgery.

Dr. Smith's excellent paper on the Noble plication procedure is extremely interesting to me. Noble originally described this procedure some years ago and most of his publications on the subject have dealt with carrying out this procedure in the face of adhesive peritonitis as one formerly saw so frequently with appendicitis. Apparently, over the years there has not been very much enthusiasm for this procedure, which I think is indeed unfortunate. Patients such as those reported by Dr. Smith in his paper present a problem to the surgeon. Most of them have been repeatedly operated upon for recurrent acute intestinal obstruction. Many of them have persistent chronic complaints. They are afraid to eat; their nutrition becomes poor and they are altogether miserable. I know of no other procedure that offers these unfortunate people with chronic small bowel obstruction any relief other than the Noble plication. Our experience with it has been quite similar to the experience reported by Dr. Smith. Our results have been quite good and, without exception, every patient that we have been able to follow has been greatly benefited by the operation. One interesting thing to me is the fact that so many of these patients will volunteer the comment postoperatively that "they feel different. The abdomen is more comfortable and feels natural." I saw a recently operated patient with Dr. Smith this morning who made this comment and the patient that he has demonstrated before us has also suggested it.

I quite agree with Dr. Smith that in those patients in whom the lower half of the small bowel is matted with adhesions and freed with difficulty and injury to the serosa, that a plication of only that portion of the bowel is indicated and brings about

(Continued on Page 794)

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Opinions, Views or Comments presented in articles appearing in this section are those of the individual authors and are not necessarily those of Oregon State Medical Society.

Willard C. Marshall Resigns O. P. S. Post

Mr. Willard C. Marshall, Salem, general manager of Oregon Physicians' Service since its inception, tendered his resignation to the Board of Directors at its July 28 meeting. The resignation was accepted with regret, effective in October after the annual meeting of the Oregon State Medical Society and the Trustees of Oregon Physicians' Service.

Marshall, who was manager of Physicians and Surgeons Hospital Association of Salem prior to the formation of Oregon Physicians' Service, was named manager of the latter when it was formed. In addition to his activity in the state medical prepaid care plan, Marshall was a long-time partner in the Gideon Stolz Company, Salem, manufacturers and distributors of bottled beverages, but for the past decade devoted most of his time to Oregon Physicians' Service.

A number of years ago Mr. Marshall submitted a resignation to the O. P. S. board at a time it appeared his private business might increase the demands on his time, but the board refused to accept it then and persuaded him to continue with the prepaid medical care plan. At that time Mr. Joseph E. Harvey, Portland, was designated assistant general manager to aid Marshall in discharge of his management duties. Harvey was named by the board to "take over" from Mr. Marshall pending official action by the Board of Directors to be selected at the annual Trustees' meeting in the autumn.

Plans for the expansion of the Gideon Stolz Company affairs have been under contemplation for some time, and with Marshall's personal participation are now scheduled for activation.

One-Package Plan Proposals Submitted to Insurance Companies

Following approval by the Council of the Oregon State Medical Society of the combined one-package O.P.S. and group insurance offering under discussion in medical circles during recent months, directors of Oregon Physicians' Service instructed that the proposals for the combined operation be submitted to all group life insurance companies licensed to do business in Oregon.

Although it was known that not all companies licensed to operate in Oregon had departments which would permit joining O.P.S. in the combined package offering, invitations to submit agency proposals were sent to all companies having head offices west of the Mississippi and a number east of the Mississippi. In all seventeen invitations to submit proposals were extended, including a number to companies whose competitive activities resulted in the O.P.S. request for approval to enter the companion insurance offering field.

In response to the invitation issued eight companies either expressed no interest or only the amount of

interest business politeness demanded. However, two companies which have had some experience in combined package offerings evidenced immediate interest and complied with the request of the O.P.S. Board. These were the Northern Life Insurance Company of Seattle and the California Western States Life Insurance Company of Sacramento. It is expected a number of other replies may be forthcoming later.

O. P. S. and Northern Life Combine In One-Package Offering

Oregon Physicians' Service and the Northern Life Insurance Company of Seattle have entered into an agency agreement whereby the Oregon prepaid medical care plan will be able to offer a number of group life and associated coverages in combination with its own doctor and hospital service contract, when such combined offerings are requested in certain medical care contracts and have been cleared through the supervisory committee or committees in the areas affected.

A contract to this effect was authorized by the O.P.S. board of directors late in July following submission of proposals to various insurance companies and became effective in early August.

At press time no "joint" one-package contract had been written and it was not anticipated many such would materialize before 1952 at the earliest, since the one-package proposals were still in process of study by a number of supervisory committees throughout the state. Thirteen such committees have approved to date.

A contract similar in most respects to that signed with the Northern Life Insurance Company is now in process of negotiation between O.P.S. and California Western States Life Insurance Company of Sacramento, but progress is slow due to the vacation season. This concern is the company which combines with California Physicians' Service to write joint one-package contracts in Northern California.

Pete the Pest Says

Operation Wing Clip: You read in the papers where Oscar Ewing, the F. S. A. top wheel, got tough with Indiana? Decided to "learn" welfare people in that state, which is where he comes from, t'ain't safe to go counter to fed'ral bureaus. Cut off their federal welfare funds, that's what he did. With great reluctance, sez he. All because Indiana welfare people had state law passed opening their own welfare records to scrutiny because they suspect some Indiana welfare users have been abusin' their ride and they wanna cull out the free riders.

What d'you think happened? The Senatorial mill, which was gnashin' away in its usual manner at S. 1099, H. R. 3341 and H. R. 3768, left that legislation danglin' while it hustled through a special rider to another bill (H. R. 2416) which provides the F. S. Administrator (which is Oscar) may not deprive a state of the federal contribution to any public

assistance program because state legislation permits public access to the program's records.

You think this is example of Washington politicians actin' on principle? Stop kiddin' yourself! Sure it could be on principle; probably didn't hurt politicians at all to know they were votin' on principle. But you can bet top reason, principle or no principle, was because they have no use for Oscar. The way things are gettin' to be in Washington it looks the best way to get a proposal knocked off is to have Oscar sponsor it, which is different from the old days.

* * *

Expensive Yak: Two Portland docs recently had lunch together in semi-exclusive club. Subject turned to question of fees and docs forgot themselves and their location as they waxed eloquent in argument of fixed fees regardless of patient, versus fee of all traffic will bear.

Advocate of all traffic will bear fee brought forth what he probably thought was clincher in citing case of reputedly wealthy lumberman being referred to him by family doctor next week. Expected to operate and get fee in four figures "because he can well afford it."

But something happened. Family doc called and cancelled appointment for his patient, so prospective consultant didn't get patient or anticipated fee.

Seems attentive gent at next table, who couldn't miss hearing fee argument, was brother of intended recipient of big fee attentions, promptly related incident to brother, who developed acute other ideas regarding his pocketbook.

* * *

Ever Seen This Happen? Head of surgical staff in active upstate hospital made great point of stressing at staff meeting the necessity of being precisely punctual in starting surgery to avoid inconvenience to later operators all down the line. Staff nodded approval when surgeon pleaded for incision to be made at time scheduled for operation, not just for surgeon to start scrubbing, and went on to other agenda matters.

So what happens? Gent who did the punctuality pleading leads off surgery next morning by showing up half hour late!

(P. S. The chap really did have a flat tire, but his colleagues, refusing "official" explanation, insist on giving him a bad time.)

* * *

No levity, please: Who is the Oregon medic who recently threw a sour ball into a local civil defense huddle by objecting with a straight poker face to including in his official capacity a certain city official and political dignitary with well-known penchant for bending an elbow? Claimed this would require the guy to be insensitive, hence of no use to committee. When point penetrated, medico was coldly told by visiting chairman to refrain from further talk until asked a direct question.

* * *

Strong medicine: Old doc who developed first-class mad at prominent oil company for cutting down his

favorite spring-forecasting tree will miss out on surprise which regretful p.r. company subordinates were cooking up. Seems company boys knew nothing of early budding qualities of tree when they ordered its removal or might have saved it. So when what's left of stump showed some signs of sprouting they set watch until it would make clear intentions to sprout or give up ghost for keeps. If it grew, plan was to get gardener to root shoot, present new tree to disgruntled doc (oil boys didn't get around to finding if rules where doc lives permit trees in apartments).

But all the plotting to restore good relations with former customer went down drain. Labrador dawg visited stump, terminated new growth with well-directed calling card.

* * *

Indirect Compliment: Americans who don't like current medical set-up may be surprised to find there are some people who do. Canadian medical school graduates. Canadians have had problem keeping their grads at home, at least enough of problem that prominent Canadian manufacturing gent named R. S. McLaughlin donated "more than \$1,000,000" for foundation to promote health and welfare of Canadians. Health and welfare has old suspicious familiar ring south of the 49th parallel, but McLaughlin's ideas seem a trifle different from Harry's and Oscar's. McLaughlin fund will be issued in form of grants to graduates of Can. medical schools who intend to devote their lives wholly or in part to medical teaching. Grants are to enable them to visit medical centers anywhere important new work is being done. Any promising clinical and medical research work done in Canada will also receive support. Donor McLaughlin voiced hope foundation will "help stop the exodus of brilliant young Canadian doctors to the United States."

Case you're wondering aboot this canny Scot, he comes from Oshawa, Ontario, and is the McLaughlin of McLaughlin-Buick, Canadian counterpart of G.M.'s Buick motorcar set-up. Old time carriage maker.

Idle thought: Has Mac been reading about Ford Foundation, or are Canadian inheritance and income taxes mighty high, too?

* * *

Egg Ad: Prominent Portland medico has had running friendly feud with fellow staffer of prominent hospital over quality of food served patients in joint. Prominent gent contended food was okeh, patients were largely bellyachers because they hadn't much else to complain of. Disregarded complaints of own patients for same reason, or might have been unwilling to admit hospital of his staffing could be that way.

Second doc knew his food conditions, having made practice of dropping in on patients at meal times.

Two met at lunch time recently, decided to run gauntlet of cafeteria together. Old debate reopened, but this time old eagle eye who could see no wrong in food got shock of his life when finishing plate of meat to discover inspissated egg underneath and around plate edges.

Hit ceiling so hard durn near went through it to next floor, while lunch companion rattled table and dishes with rolling belly laugh. This was mistake,

even if spontaneous. Now first gent thinks second framed him for sake of winning argument.

Note: You can get reconciled, boys. There was no frameup, just run of the cafeteria service. Happens whenever there are eggs for breakfast. Low steam pressure account of surgery demand.

* * *

You wanna Pension?: New Yorker named Ives, cavorting in national senate, has introduced bill proposing to exempt docs, dentists, actors, writers and lawyers from paying income taxes on some of their earned income if they are paying into "approved" retirement funds of their "associations."

You don't have to pay taxes (if the gent gets his law) on premiums paid into such deals if they don't total \$7,500 annuoly or exceed 10 per cent of yer income. So you can get yer hands on some dough when you earns it. Catch is it isn't tax exemption. Just defers payment until you start drawing from pension fund at age 60 or sooner if disabled. Then you whack up wid Uncle Whiskers.

May be other bugs, too, so don't git too excited. Similar bills also sponsored by three fellow New Yorkers who are Democratic members of H. of R. Makes thing look like politics and sure enough the dark gent in the woodpile is New York Bar Association (nothing to do with nightclub fleshpots) which has been advocating somethin' of sort for yars.

Wanna bet sponsorin' gents aren't comin' up for re-election, say about '52, need lawyer support?

* * *

Who said Sheep?: Portland hospital much concerned with intern matters, "quotas" and "matching plan," recently telegraphed official of N.C.I.I. (you know what that stands for, Joe?) wantin' dope on how American hospitals were linin' up on matching plan bids. Got telegram back which looked like runaround, same as federal bureaucrats dish out, because request for info. was "referred to American Hosp. Assoc. for reply." Few days later actually got reply from A.H.A. on poll of hospitals' stand on marching plan.

Gist: 780 hosps. polled, representing 9,351 internships; 632 representing 7,617 intern jobs replied. Out of replies 573 hosps. representing 6,000 plus internships favored matching plan; 59 hosps. representing 674 internships were agin it.

Comment: In 59 hosps. agin program, five were

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from Portland! (One Portland hospital unit was for the plan.)

Now Portland hospital which sent telegram is wondering if it is overwhelmed by majority which is right, or is in the far-sighted minority which, upon analyzing the proposals concluded there wasn't much future in self-imposed regimentation setting up conditioned reflex for possible national socialism.

* * *

Ad Hoc: Iggerunt doc, readin' dope from N.I.I.C. (pernounced like "Nick" but meaning National Inter-association Internship Committee) wants to know

what is this *Ad Hoc* committee which give committee its start.

Sorry, bud, this kinda *hoc* got nothin' to do with beer. It jes' means "regarding this thing," sez Latin-spoutin' drugstore friend.

So, sez iggerunt doc, reflectin', a "regarding this thing" committee is what starts this ruckus. Kinda self-startin', too, ain't it?

Whazza matter, rejoins pal, you wanna get rooked by jes' any ord'nary committee? Ain't you impressed by havin' job done by committee which rates a *Ad Hoc* jughandle in fronta it?

Progress of Willamette Valley Chest X-Ray Survey

Results of the Willamette Valley Mass Chest X-Ray, although falling somewhat short of the expectations of its sponsors, will lessen the burden of other agencies in the eight counties in ferreting out the cases of early tuberculosis. This is the indication as more than half of the survey is completed.

Official report on 100,358 persons whose small or 70-millimeter film have been "read" by the doctors on the interpretative staff at headquarters show 2,573 individuals have been asked to return for a retake on a 14x17-inch film.

From among this group indications were that 465 of the large films showed the presence of tuberculosis in some form but with the exclusion of 71 cases listed as only "suspected tuberculosis" actually there were 394 cases of the disease in some of its phases. These latter cases will be followed up by the personal physicians of the participants.

Of this number of cases 272 are classed as minimal, 106 as moderately advanced, 10 far advanced and six unclassified.

The program was jointly initiated by the Oregon State Board of Health and the Oregon State Medical Society with the endorsement of the Oregon Tuberculosis and Health Association. The efforts of these organizations are being correlated in the survey by The Willamette Valley Chest X-Ray, Inc., a corporation formed to handle the financial as well as the physical phases of the program.

The corporation named Dr. Clair V. Langton, of Oregon State College, program director and the U. S. Public Health Service named Dr. B. E. Bennison to direct the medical and technical group furnished by the government. The sponsoring organization, The Willamette Valley Chest X-Ray, Inc., elected Robert M. Ashby president of its group.

It was the aim of the co-operating groups to conduct a 100 per cent x-ray of the estimated 390,223 adults in the eight counties of Washington, Clackamas, Yamhill, Polk, Marion, Linn, Lane and Benton.

The public health service loaned 18 mobile x-ray units, dark room equipment, special office equipment and instruments for quick and accurate "reading" or interpretation of the miles of exposed 70-millimeter film used in the survey. In addition to almost \$1,000,-

000 worth of equipment and material, the public health service also furnished technicians to operate the machines, experts to direct the work in office and field and also furnished a competent group of medical men to interpret the film.

The state medical society co-operated in the survey by appointing several special committees which in turn met with the public health service workers and helped to lay the base on which the survey is being conducted.

The state health department has made available its technical knowledge of the counties in the survey and in addition Dr. Harold M. Erickson, state health officer, named several of his assistants and health workers to assist with the survey. They still continue in the survey, giving as liberally as they can of their time from their own responsibilities as state employees.

The state's tuberculosis association has done the same thing.

Survey officials now know for a certainty that the coveted 100 per cent goal cannot be reached. There is a feeling of confidence, however, that the x-raying to date in four counties of 100,380 adults of a potential 161,494 persons will prove of great help to the authorities who have hitherto carried the burden of finding and controlling tuberculosis.

For instance, until the arrival of this large volume of equipment the fight for the discovery and control of early cases of tuberculosis had been carried on by the medical profession, the state board of health, county health department and the tuberculosis association.

Due credit is, and in all fairness should be, given to the individual members of the medical profession who are tilling the fields every day, year in and year out. They actually have found more cases of tuberculosis than was discovered in the chest x-ray survey conducted constantly by other health agencies in the state during the past six years, according to the Oregon State Board of Health.

The state department of health has been operating two mobile x-ray units and the tuberculosis and health association another. Also the Portland Bureau of Health and Multnomah County Health Depart-

ment are operating a stationary survey center in Portland.

These agencies have given and are continuing to give excellent service. However, the tuberculosis association recently had to withdraw its unit from the statewide program because of a mechanical defect which made it advisable to limit the unit's travel to a minimum. However, the unit is still operating in the Portland Multnomah area.

Dr. Harold M. Erickson, state health officer, is authority for the statement that these additional 18 x-ray units could accomplish in 13 weeks as much as the present available equipment might complete in three years.

One of the favorable reactions to the Willamette x-ray survey is found oddly enough in its economic appeal. Oregon has an estimated base cost of \$2,400 per year for individual cases of tuberculosis which have reached the hospital or sanitarium stage. When doctors pointed out that the mass x-ray will reveal tuberculosis in its early stages, when it can be cured at a minimum cost and waste of time, it was apparent that the x-ray use also would reduce the tax cost which has become a heavy burden on taxpayers.

This fact coupled with the natural tendency of civilization to maintain humanity in health and subsequent comfort led the lay groups and individuals to follow readily the x-ray program which is strictly medical and is being conducted as such under strict medical supervision.

To build the framework for the survey each county organized a group of its own with a County chairman and publicity chairman down to small groups of workers in each community. Professional health workers from the U. S. Public Health Service, the Oregon State Board of Health, the Oregon Tuberculosis and Health Association and from the individual county health departments held meetings and conferences with these groups until they became oriented in the details of procedure.

The government made an agreement with the legal sponsors in actuality that brought a given sum for the operation in addition to equipment and material. The sponsoring area group in turn obligated itself to raise \$32,273.77 equal to 16 times the estimated population of the entire eight counties. Each county then agreed to raise its proportionate share of the money based on the individual county's estimated population.

The government furnished location experts who met with the community groups in each county and helped them to decide on the spots where the mobile units would be located and the period of time they would operate in those spots. When the entire area had passed through this phase of the survey a master locations sheet was printed showing the tentative location of each numbered mobile unit throughout the survey. Some changes were made in these locations from time to time to catch special events such as fairs, baseball games, transient labor overflows such as accrue in harvesting seasons as in beans, fruit and hops. Generally, however, the master schedule was adhered to.

During this organization stage the health workers and the executives from county and general headquarters gave every assistance in soliciting and training local help for service in the county and general headquarters. Hostesses were selected and trained to meet prospective participants. Once trained they station themselves at the units and solicit individuals to enter the units.

Machines are often located at industrial establishments and usually a preregistration is made there and the resultant "take" at these stations is not only heavy but very rapid. Technicians operating the machines are furnished by the government, all being highly trained to do their job efficiently, with the utmost courtesy being shown participants.

When a roll of film, capable of holding 350 chest pictures, is completely exposed it is returned at once to headquarters where it is developed and dried at once. Taken in rolls to the "records" department each individual picture is then matched with the registration card of each person who entered the unit for a picture. Each participant's card is inserted in the x-ray in such a manner as to leave name and number of participant on the exposed film. This rules out any possibility of error between film and participant.

Once the film and x-ray are paired they are sent to the reading room where a corps of medical men from the public health service interpret and post their findings on the cards. Each roll of film is read by two different doctors and many of them are widely discussed by the working doctors as a group.

If their findings show a chest picture indicates good health the individual involved in the picture is so notified by post card. If, on the other hand, there is an indication of some ailment in the chest picture the individual in this case is notified by sealed letter, the envelope even being plain, that a retake picture should be made.

Very precise records are kept on potential retakes and every effort is made to get these individuals to return for a larger picture. For the convenience of these persons each county has a retake center of its own. In the event an individual is requested to return for a retake and fails to show up before the center is closed, efforts are continued by the survey and also by local health authorities to have him return. If the local retake center closes before all second pictures are taken efforts are continued to try and get these persons to headquarters center or to their private physicians.

If the large picture definitely reveals tuberculosis the participant is then referred to his or her private physician. In cases where some other abnormal chest ailment is apparent the participant is interviewed by health officials at the center or is advised to see his or her private physician.

In many instances persons requested to return for a retake elect to see their personal physicians for their second x-ray instead of returning to the center.

Many are the chores before a participant finally reaches this point. In between are the efforts of the local groups in fabricating plans for raising money to pay the county's share of the survey. Included

in these are pie socials, festivals, breakfasts by individuals who charge a fee and then donate the proceeds to the community fund. In other areas milk bottles are used but they are never placed where participants entering the units can see them.

In one area a labor union raised \$350 the "hard way," then challenged "business" to match it. Business was a good little boy.

In devious ways the counties added nickles to pennies, pennies to dimes and dimes to dollars to come up with their share and with few complaints.

One of the features of the survey but seldom commented on by the press or the radio is the enthusiasm of the participants. Many times when a unit seems overloaded the "line" jests and has fun as it melts into the unit.

Medical Notes

Notes From the Medical School

Enrollment at the University of Oregon medical school reached 295 students this fall. Eighty-three freshmen registered, including four women.

The appointment of three new instructors has been announced, as follows:

DR. HUGH R. K. BARBER has been appointed Assistant Professor of Obstetrics and Gynecology.

DR. WILLIAM EARL SNELL received his appointment as Instructor in Orthopedic Surgery.

DR. ROBERT A. ALDRICH has been appointed Assistant Professor of Pediatrics.

The University of Oregon Medical School has received the following gifts and grants:

A grant of \$21,600 from the Atomic Energy Commission to be utilized under the direction of Dr. Edwin E. Osgood, Professor and Head of the Division of Hematology, and Dr. Arthur J. Seaman, Assistant Professor of Hematology.

A grant of \$15,000 from the National Fund for Medical Education to be used at the discretion of the Dean of the Medical School.

A grant of \$8,000 from the U. S. Public Health Service for research to be conducted under the direction of Dr. Archie Tunturi, Assistant Professor of Anatomy.

A grant of \$6,000 from the John and Mary Markle Foundation of New York, the first of five yearly grants to be utilized for salary payment of Dr. John E. Harris, Department of Ophthalmology.

A grant of \$5,833 from the U. S. Public Health Service for a research project under the direction of Dr. Howard L. Richardson, Assistant Professor of Pathology.

A grant of \$5,400 from the U. S. Public Health Service for a cancer research project to be expended under the direction of Dr. Charles M. Grossman, Clinical Instructor in Medicine.

A grant of \$5,199 from the U. S. Public Health Service for research being conducted under Dr. M. E. Steinberg, Research Associate in the Department of Physiology.

A grant of \$4,995 from the U. S. Public Health Service for a research project in the Department of Physiology entitled, "A Study of the Pyramidal System."

A grant of \$3,200 from the U. S. Public Health Service for a continuation of research being conducted

under the direction of Dr. Anthony A. Pearson, Professor of Anatomy.

A gift of \$3,000 from Mrs. Don McGraw for the McGraw Research Fund in the Department of Medicine to be utilized for carrying on investigation in heart disease.

Other miscellaneous gifts totalling \$1,350 have been received by the Medical School in the past six weeks.

Sixty-eight Doctors Granted Licenses

George H. Lage, M.D., president of the Board of Medical Examiners, announced that 68 doctors were licensed in August to practice medicine and surgery in the State of Oregon. Thirty-six of the candidates have been issued licenses to practice medicine and surgery after passing recent state medical board written examinations. Those receiving such licenses are:

In Portland: Edgar H. Anderson, Jr., M.D.; Ksenia Beetem, M.D.; Richard M. Bernard, M.D.; Eileen Brenneman, M.D.; Robert H. Buckinger, M.D.; Theodore R. Deems, M.D.; Robert E. DeLorme, M.D.; Merle E. Foland, M.D.; C. H. Hagmeier, M.D.; Allen P. Hargraves, M.D.; R. Dale Hunsaker, M.D.; Toshio Inahara, M.D.; Kimball C. Kaufman, Jr., M.D.; Kenneth L. Martin, M.D.; Edwin A. Mickel, M.D.; Clarice Nordlum, M.D.; Barbara J. Radmore, M.D.; Thomas L. Stern, M.D.; Carolyn F. Taylor, M.D.

Other than Portland: Joseph T. Abbott, M.D., Fort Lewis, Wash.; Leroy V. Casey, M.D., Dallas; William Charles, M.D., Dallas; Ralph W. Eichenberger, M.D., Norman, Okla.; Emanuel M. Honig, M.D., Topeka, Kas.; Donald M. Jeppesen, M.D., Oregon City; V. Ellis Knight, M.D., Kimberley, Idaho; Elton D. Leavitt, M.D., Sandy; Richard W. McLean, M.D., Reedsport; Gordon C. Myers, M.D., Chicopee Falls, Mass.; Robert C. Pittinger, M.D., Medford; Joseph P. Stampher, M.D., Whitefish, Mont.; Robert B. Sullivan, M.D., Vancouver, Wash.; Robert M. Turner, M.D., Ashland; D. E. Tyler, M.D., Ontario; Elmer P. Wedel, M.D., Salem, and Albert E. Wilkinson, M.D., Tigard.

Dr. Lage announced that 32 candidates were licensed to practice medicine and surgery, having based their applications upon reciprocity with a sister state or endorsement by the National Board of Medical Examiners. Those receiving such licenses are: Carl U. Albertson, M.D., North Bend; Mary Beyer Ames, M.D., Astoria; Grover C. Carter, M.D., Hood River; John L. Cockrell, M.D., Eugene; Nicholas Demmy, M.D., Port-

land; Lowell S. DeVoe, M.D., Oregon City; Peter DeWitt, M.D., Oakridge; Chesmore Eastlake, Jr., M.D., Portland; Gordon O. Erlandson, M.D., Klamath Falls; William P. Galen, M.D., Portland; J. Andrew Hall, Jr., M.D., Grants Pass; R. Ray Johnson, M.D., Grants Pass; James R. Kiger, M.D., Corvallis; Donald M. Love, Seaside; John Clifton Massar, M.D., Portland; Menzie McKim, Jr., M.D., Baker; Lloyd A. Meade, M.D., Portland; N. E. Medved, M.D., Portland; Ralph F. Meincke, M.D., North Bend; Vernon E. Mikkelsen, Jr., M.D., Circle Pines, Minn.; Charles E. Reed, Jr., M.D., Corvallis; Robert W. Reubendale, M.D., Vancouver, Wash.; Murray E. Robinson, M.D., Klamath Falls; Paul E. Shick, Jr., M.D., Portland; John C. Stewart, M.D., Oak View, Calif.; Edward H. Strauss, M.D., Florence; George W. Teller, M.D., Eugene; Howard R. Wetzel, M.D., Tacoma, Wash.; John H. Whitmer, M.D., McMinnville; James W. Woolery, M.D., Portland; Philip D. Christensen, M.D., Portland, and Marvin M. Lacy, M.D., Portland.

The next written examination will be held in January, 1952, and the next regular meeting of the board is set for October 12 and 13, 1951.

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WASHINGTON STATE MEDICAL ASSOCIATION



ANNUAL MEETING SEATTLE, SEPT. 14-17, 1952

President, R. A. Bensan, M.D., Bremerton Secretary, Bruce Zimmerman, M.D., Seattle Executive Secretary, Mr. R. W. Neill, Seattle

State Convention Briefs

There were several rough spots and equally as many opportunities for improvements, but reports to date indicate the Annual Convention of the State Association was highly successful. Not one serious complaint has been received in the Central Office. With this remark, we open the way for constructive criticism which is always welcome.

Most difficult feature of the Convention to handle with any degree of satisfaction to all concerned is the Scientific Exhibit. Lack of proper space is the main hindrance, and, while plans are in the making to correct this deficiency, there is little real assurance of success. The physicians who willingly face obvious difficulties to enter their exhibits in order to enhance the scientific program are to be commended for their patience and endurance.

You may not have agreed in all respects with the choices of the Nominating Committees, in the few years they have been functioning, but you will have to admit the Committees' selections have increased interest in the elections of State Association officers. It is no longer necessary for the Speaker to make nominations from the rostrum, which has occurred in the past.



Delegates are shown paying close attention during deliberations of the House in the Junior Ballroom of the Olympic Hotel, Sunday, September 9. The photograph was taken from the Speaker's rostrum.

Physicians registered for the Convention totaled 914. Twenty medical students and seven interns made known their presence at the registration desk. Indications are that many Seattle physicians ran in and out of the Convention programs and attended the social events without registering.

After witnessing the A. M. A. Convention in Atlantic City last June, President K. L. Partlow of the W. S. M. A., (now past-president and chairman of the

Executive Committee) determined there should be a reception for our new president. Accordingly it was ordered. Usually, during the final session of our House of Delegates, the new president is escorted to the rostrum, is handed the gavel, and in so many words is told to go on about the business of "taking it on the chin" for the ensuing year.

This year, in addition to that little ceremony, R. A. Benson, new Association president, and Mrs. A. J.



The President's Dinner for the Board of Trustees and the Scientific Works Committee and Convention Committee Chairmen was held at the Washington Athletic Club, Saturday, September 8.

Bowles, of Seattle, new Auxiliary president, were given a reception in the Junior Ballroom. It turned out to be one of the most delightful events of the 1951 Convention, and gave the final and deserved finesse to the procedure of starting the new leaders happily on their way. The reception was scheduled for two-hours duration, but was extended to about double that time, as the occasion demanded.

Another event that rates special mention is the Annual Banquet and Dance. The Olympic Hotel broke precedent by closing the Georgian Room to the public for this affair. Approximately 525 people attended. Indicative of the keen enjoyment of the occasion were the many requests to continue the dance for another hour. This was a distinct compliment to Jackie Souders and his band, who extended themselves beyond expectations. Because this party was so popular, consideration is being given to the possibility of using both the Olympic Bowl and the Junior Ballroom for dancing. Such an arrangement would relieve congestion and make even a better party.

The Olympic Hotel management has informed the Association of its pleasure and appreciation for the opportunity of being host to the Convention, "because

it is so well managed, the doctors arrange the nicest parties, and because the doctors and their wives are guests who are most appreciative of the Hotel's efforts." That is quite a compliment. The Hotel too deserves much credit. The management and its employees "broke their collective necks" to carry out their part of producing a smooth-running Convention. The Hotel has been so informed.



D. H. HOUSTON, M.D.
the Taylor Trophy, which was claimed by J. T. Kerns, Grant County.

The Golf Tournament, according to Chairman Dan Houston, had the biggest entry list of all time and the calibre of golf was excellent. Prizes for golfers and fishermen were awarded at a fun-fest held in the Seattle Golf Clubhouse Monday evening.

A number of beautiful prizes were carried away. Chief of these were the President's Trophy, contributed by President Partlow and won by Bob Evoy, King County, and

Most noticeable "hitch" in the whole Convention program was the extension of the Wednesday morning scientific program into the Public Relations Luncheon hour. Moderators and presiding officers at these programs will have to assume their obligations of "rapping down" the speakers, or it will be necessary for the Program Chairman to arrange the length of the morning program to provide plenty of time for the table set-up for the luncheon. Medical economics and public relations are necessary items for our Conventions and round out the program to meet all necessities. Care must therefore be taken in the future to prevent encroachment of one program upon another.

When the armada of doctors invaded Puget Sound, most of the Salmon skeddaddled right out into the Pacific Ocean, and few catches were registered in the Salmon Fishing Derby. But, everybody had fun. Several over-anxious dry-land physicians, not too accustomed to the wily Salmon, had good strikes but failed to boat them. Attractive Mrs. Lowell Hill won first prize with a beautiful 13-pound 13-ounce salmon. Chairman Edmund Smith said the Derby was a great success, despite the small number of catches. Plans are going forward for next year.

Another departure from former years was the daily Convention Bulletin issued on Monday, Tuesday and Wednesday. The pictures were taken by a staff member with office equipment, and the reporting was done by Mary Frear of NORTHWEST MEDICINE. Comments on the Bulletin were very favorable.

Whitaker & Baxter, who attend many state medical conventions, were very favorably impressed and said it is the first time it has been done by a State Association. Proper distribution of the Bulletin was a problem, and as a result the Central Office has a small number of sets of the Bulletin on hand for those who want them.

Of considerable interest is the following letter, received in the State office the week following the Convention; from the Public Relations Department of the American Medical Association:

Mr. Ralph W. Neill, Executive Secretary
Washington State Medical Association
338 White-Henry-Stuart Building
Seattle, Washington

Dear Ralph:

Our heartiest congratulations to you on being the first state medical society to publish a Convention Daily Bulletin. We have read with much interest the three bulletins which you sent to us and like to feel that perhaps the transformation of our own *Bulletin* might have suggested this project to you.

I have gone through the newspaper publicity of your meeting which was sent to us. This certainly is encouraging and demonstrates the cooperation you are getting from your local press.

Sincerely yours

(Signed) Leo E. Brown

Assistant to the General Manager

Jim Borgen of Bremerton was elected president of the Medical Bureau Managers Association during the State Convention at the bureau managers' business sessions. Bill Greger of Chehalis was elected secretary. Borgen, manager of the Kitsap County Bureau, succeeded Harold Brown of the Chelan County Bureau and Greger, manager of the Lewis County Bureau, succeeded Borgen as secretary.

MRS. ROBERT FISHBACH of Winlock was named president-elect of the Woman's Auxiliary during the convention, succeeding Mrs. A. J. Bowles of Seattle, who became president. Mrs. Bowles succeeded Mrs. R. M. Schulte of Spokane.

Vice-presidents elected are Mrs. Charles McArthur of Olympia; Mrs. Erwin Slade of Snohomish; Mrs. J. R. Rehal of Stevenson; Mrs. Laurie J. Hakala of Aberdeen; Mrs. H. F. Brundage of Yakima; Mrs. O. O. Christianson of Spokane, and Mrs. P. D. Brink of Pomeroy.

Mrs. L. S. Highsmith of Spokane was elected secretary and Mrs. Donald Evans of Seattle was re-elected treasurer.

One of the most successful affairs of the whole Convention was the Sunday night Family Dinner, during which H. E. Rhodehamel of Spokane was honored as the "Outstanding General Practitioner of

(Continued on Page 791)

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Never Before So Many Convention Pictures



1. Hard-working Secretary-Treasurer J. W. Haviland, Seattle, supplies information for the House of Delegates.

2. R. A. Benson, left, with Speaker Jared as Benson takes over the office of President.

3. The House of Delegates hears report of Committee on Reports, given by Bernard Harrington of Tacoma.

4. Mrs. A. J. Bowles, Seattle, new President of Woman's Auxiliary, taking a bow at head table during Public Relations Luncheon. Frank H. Douglass, Seattle, Chairman of the W. S. M. A. Public Relations Committee, is at left and President Partlow and Clem Whitaker are at right.

5. Clem Whitaker addressing Public Relations Luncheon. President Partlow gives close attention.

6. Clarence A. Smith, 91, Editor Emeritus of Northwest Medicine, takes in final session of the House of Delegates. Doctor Smith was given a standing ovation.

7. A. J. Bowles, Seattle, Chairman of Resolutions Committee, and former President of W. S. M. A., reports to the House of Delegates.

8. Mrs. R. M. Schulte, Spokane, reporting Auxiliary activities to House of Delegates. Mrs. Schulte was succeeded as President of the Auxiliary by Mrs. A. J. Bowles of Seattle.

9. Leone Baxter, member of the A. M. A.'s Public Relations firm, Whitaker & Baxter, addressing Public Relations Luncheon. Mr. Whitaker is at left.

10. President Partlow, Speaker Jared and Chairman Bowles are shown at the Speaker's Table while the House of Delegates discusses the report of the Resolutions Committee.

11. Enjoying Public Relations program at head table are Miss Baxter, Mrs. R. M. Schulte, Spokane, and D. G. Corbett, Spokane, Chairman of the W. S. M. A. Executive Committee and past president.

President's Reception Gala Occasion



Precedent was set Wednesday evening, September 12, at the Olympic Hotel, when the Washington State Medical Association held its first official President's Reception as a part of the convention program in the Junior Ballroom. Among those in the social spotlight were:

Above: Left—Admiral Dan Hunt (Retired) of Tacoma chats with Mrs. R. A. Benson. Center—R. L. Zech and

A. J. Bowles, both of Seattle, and both past presidents of the Washington State Medical Association, enjoy a chat. Right—A Tacoma trio at the President's Reception, Jesse W. Read, Mrs. Read and Bernard Harrington. Below: Left—Mrs. A. J. Bowles of Seattle, right, new President of the Woman's Auxiliary, chats with Mrs. L. A. Campbell of Olympia, center, Auxiliary Legislative Committee Chairman, and Mrs. R. W. Neill, Seattle. Right—Most popular man at the reception was the new President of the State Association, R. A. Benson of Bremerton. He is shown with Mrs. Benson, left, and Mrs. Harry P. Cain, of Tacoma, right, wife of the U. S. Senator.



As Revealed by Ralph Neill's Candid Camera

There were personalities galore on the convention program. Among them were:

Above: Left—A. O. Adams, Spokane, Chairman of Committee on Physicians Selective Service, addressing delegates. Center—Ernest M. Burgess, Seattle, reporting on negotiations with State Department of Labor and Industries for an increase in medical fee schedule. Right—C. E. Watts smilingly acknowledging election as President-Elect of Washington State Medical Association. He takes office next September, but meantime becomes a member of Executive Committee and Board of Trustees.

The very successful state convention was highlighted by a number of unusual events and new innovations. Outstanding among them was complete camera coverage of all events taking place. Ralph W. Neill, executive secretary of the Association, took dozens of pictures and managed to be many places *almost* simultaneously, in order to accomplish the fine display of photographs.

Many of the photographs Mr. Neill snapped were used to make possible the daily convention bulletin, which enabled the Association to be the first to publish such a bulletin.

We are pleased to have the opportunity to print, at left and above, others of the many pictures which recorded the exciting and gala events of the 62nd annual convention.





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Full name of each guest. Please do not include a physician as a guest. Every doctor must register in his own name.

State Convention Briefs

(Continued from Page 786)

Washington State" for the year of 1950. These selections are made in the fall of each year, the Certificate of Honor being awarded at the Convention following. The "Outstanding G. P." for 1951 will be selected early in November.

R. D. Reekie, a fellow-townsmen of Rhodhamel's, was as "outstanding" in his presentation of the award as Rhodhamel was in accepting it.

As a result of the Convention elections, the following now constitute the Executive Committee of the Association:

R. A. Benson, Bremerton, president; C. E. Watts, Seattle, president-elect; K. L. Partlow, Olympia, past-president; and Bruce Zimmerman, Seattle, secretary-treasurer.

The elections also caused some shift in the membership of the Board of Trustees, which now consists of the following:

R. A. Benson, chairman, Bremerton; K. L. Partlow, Olympia; C. E. Watts, Seattle; I. E. Munger, Vancouver; Bruce Zimmerman, Seattle; W. A. McMahon, Seattle; A. G. Young, Wenatchee; R. L. Zech, Seattle; R. D. Wright, Tacoma; M. Shelby Jared, Seattle; V. M. Spickard, Seattle; J. H. Berge, Seattle; Frank Wanamaker, Seattle; Jack D. Freund, Kennewick; Bernard D. Harrington, Tacoma; Quentin Kintner, Port Angeles; John Hardy, Endicott; W. C. Moren, Bellingham; David Metheny, Seattle; A. O. Adams, Spokane; E. L. Calhoun, Aberdeen; W. L. Ross, Yakima; J. F. Christensen, Kelso; D. W. Gaiser, Spokane; B. C. Koreski, Yakima; Jesse W. Read, Tacoma.

Medical News

New Officers of WSMA Elected

C. E. Watts of Seattle was selected by the House of Delegates as the president-elect of the Washington State Medical Association. He succeeds R. A. Benson of Bremerton, who took over the presidency, replacing K. L. Partlow, who, as the immediate past-president, becomes chairman of the Executive Committee.

Watts is a former president of King County Medical Society and was chairman of the committee which organized the Washington State Health Council.

I. E. Munger of Vancouver was elected vice-president, succeeding Arthur E. Lien of Spokane and Bruce Zimmerman of Seattle succeeded James W. Haviland of Seattle as secretary-treasurer. Haviland had served three years in that position and one year as assistant secretary-treasurer and did not stand for re-election.

William A. McMahon of Seattle was elected assistant secretary-treasurer and M. Shelby Jared of Seattle was re-elected speaker of the House. A. G. Young of Wenatchee was re-elected A.M.A. delegate and Fred Harvey of Spokane alternate.

Elected to the Board of Trustees were:

East side, two-year terms: A. O. Adams, Spokane; W. L. Ross, Yakima. West side, two-year terms: Emmett L. Calhoun, Aberdeen, and Quentin Kintner, Port Angeles.

Trustees-at-large, one-year term: David Metheny, Seattle; W. C. Moren, Bellingham; John Hardy, Endicott; Jack D. Freund, Kennewick; Bernard Harrington, Tacoma, and Frank Wanamaker, Seattle. Homer Humiston of Tacoma was elected a member of the Finance Committee, succeeding W. H. Goering, also of Tacoma.

Plans Under Way for Diabetes Week

Plans are on hand by members of the Diabetes Committee of the Washington State Medical Association

and those of the Washington Diabetes Association for the fourth year of activity, ably spearheaded by the Diabetes Week, November 11-17, 1951. Each year reveals that there is more public approval of this attempt by the part of the lay in testing family members, school children, industrial employees and others.

The general practitioner has great influence towards encouraging the carrying out of this program by the retesting of each patient and his family, especially when diabetes is present, the use of the self-tester which may be purchased at a very nominal fee, or to conform to concentrated efforts during the designated Diabetes Week.

The most earnest cooperation by members of the many county societies towards this very worthy example of public relations in the hands of the private physician is urged with the beginning of Diabetes Week, and the perpetuation after its instigation for the ensuing year.

If anyone has an undiagnosed case of diabetes, the screening will bring it to light through the above efforts before it has a chance to become more serious and harder to control.

Release to All County Medical Societies Regarding Warning on Cortogen Acetate Ophthalmic Suspension

The following communication from R. T. Stormount, Secretary, Council on Pharmacy and Chemistry, should be noted by every member:

"Schering Corporation of Bloomfield, New Jersey, has advised the Council office that a shipment of its ophthalmic preparation of cortisone acetate marketed under the trade name Cortogen Acetate Ophthalmic Suspension is contaminated with *Pseudomonas aeruginosa* organisms. Although only one batch of the material may be contaminated, the firm informed

this office that telegrams have been sent to all their wholesale and retail outlets as well as to all ophthalmologists in order to effect a complete recall of all shipments of the drug. Physicians who have any Cortogen Acetate Ophthalmic Suspension on hand at this time would be well advised not to administer it to their patients.

"An ethical drug firm undertakes all measures necessary to remove from the market a product suspected of being contaminated or adulterated, particularly if there is any danger at all of the article causing injury. Immediate action of this kind by the reputable pharmaceutical manufacturer often obviates stringent regulatory action by the Food and Drug Administration. Schering Corporation is to be commended for its prompt action which is in the best interests of the medical profession as well as the general public."

Announcements of Meetings

Seattle Academy of Internal Medicine

The final quarterly meeting of the Seattle Academy of Internal Medicine will be held Monday, October 22, in the Ballroom of the Edmond Meany Hotel. The meeting will begin with a social hour at 6:30 p. m., followed by dinner.

Guest speaker for this meeting will be J. Douglas Robertson, Department of Clinical Investigation, London Clinic, London, England. His subject will be "Normal and Abnormal Basal Metabolism; Therapy of Hypo- and Hyperthyroid States."

The Seattle Academy of Internal Medicine will have as guests for this distinguished speaker members of the Tacoma and Spokane Academy of Internal Medicine.

The January meeting of the Seattle Academy will be the annual meeting, featuring election of officers. Further details of this meeting will appear in NORTHWEST MEDICINE at a later date.

Regular monthly meeting of the Walla Walla Valley Medical Society was held at the Grand Hotel with the regular social hour beginning at 6:30 p. m., Thursday, September 13, 1951.

George A. Boylston of Portland spoke on "Ulceration of the Stomach Both Benign and Malignant."

A committee composed of J. T. Rooks and H. A. Mount presented a resolution expressing the loss to the society in the death of Elmer Hill. The resolution was made a part of the permanent record of the society.

September 5 meeting of the Chelan County Medical Society found 54 members and guests attending at the Cascadian Hotel, Wenatchee. The scientific portion of the meeting was provided by a paper by James W. Miller, Seattle, who spoke on "The Conservative Management of Diabetic Feet." An additional topic concerning Cortisone and ACTH was provided by Joseph H. Crampton, Seattle. Dr. Crampton also covered "The Management of Diabetic Coma."

Fair Exhibit Clicks

The Washington State Medical Association and the Washington State Medical Bureau jointly sponsored a fine exhibit at the Western Washington Fair.

The showing was a replica of the A.M.A. convention booth on "Benefits from Animals in Research." It consisted of four handsome, well-lighted panels flanking a projection screen which carried a running story of the many great benefits which have accrued to both man and animals through the use of animals in research.

This exhibit, shipped here especially for the Puyallup showing, attracted many interested observers and caused much favorable comment.

Thousands of pamphlets on voluntary prepaid medicine and the continuing threat of "socialized medicine" were distributed.

Spokane Academy of General Practice will hold the fourth annual meeting on December 1 at the Spokane Hotel, Spokane.

Guest speaker will be Philip Thorek, Chicago, who will present papers on the following subjects: The



PHILIP THOREK, M.D.
Chicago

Acute Abdomen; Intestinal Obstruction; Jaundice; Vagotomy and the Ulcer Problem. Dr. Thorek is clinical assistant professor of surgery, University of Illinois; associate professor of surgery, Cook County Graduate School of Medicine; diplomate, American Board of Surgery; fellow, American College of Surgeons; fellow, International College of Surgeons; fellow, American College of Chest

Physicians; member, American Association of Anatomists; chief surgeon, American Hospital; attending surgeon, Cook County Hospital; senior attending surgeon, Alexian Brothers' Hospital.

Dr. Thorek has just had his recent book entitled "Anatomy in Surgery" published by the Lippincott Company. An interesting note regarding this work is that all of the copies printed in the first printing (5,000) were sold before the book was announced at the June, 1951, A.M.A. meeting in Atlantic City. This is quite an unusual record for book selling. The book is now in its second printing.

Dr. Thorek has made a group of medical films, 68 in number, which he makes available to the medical profession. He has also written many contributions to medical literature—his bibliography numbers about 76 articles.

There will also be papers by six members of the Spokane Academy of General Practice. The titles of these papers are not yet available.



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Nuclear Substances to Be Subject of Lecture

John H. Lawrence, Bonner Laboratory of Medical Physics, University of California Medical School, Berkeley, will present a lecture at the University of Washington auditorium at 8:15 p. m., on Friday, November 9. Dr. Lawrence's subject will be "Current Uses of Nuclear Substances in Diagnosis and Treatment."

This lecture is given under the auspices of the Phi Delta Epsilon medical fraternity, and is sponsored by the Phi Delta Epsilon Graduate Club of Seattle. The lecture is the annual Aaron Brown Memorial Lecture.

Medical Bureau Has New Name

Stockholders of Washington State Medical Bureau at their annual meeting in Seattle on September 9 changed the name of their organization to Washington Physicians Service and amended Articles of Incorporation to legalize the change in name, according to John Steen, manager.

Mr. Steen announces the following slate of officers which were nominated and elected at the meeting to serve during the ensuing year: A. G. Young, incumbent, Chelan, re-elected president; Quentin Kintner, Clallam, vice-president, and A. J. Bowles, King, secretary. H. E. Nichols will continue to be medical advisor, Edward L. Rosling was re-appointed legal advisor and Mr. Steen was re-appointed manager.

Legislative action of the Board of Trustees, together with the assignments to committees, will be published next month in NORTHWEST MEDICINE, according to Mr. Steen.

Discussions of Papers

(Continued from Page 776)

a very satisfactory result. It appears to be unnecessary to plicate the entire small bowel except in those instances where the entire length of the bowel has damaged serosa.

Dr. Smith has commented on his reaction to the use of a running catgut suture in approximating the loops of bowel and the mesentery in this operation and my original feeling was quite similar to his. More recently, however, I have been using the running catgut suture as described originally by Noble and I think it is thoroughly satisfactory. It is not as time-consuming a procedure; it satisfactorily approximates the bowel and the mesentery, and, perhaps most important of all, I think it contributes a margin of safety in the prevention of such an accident as Dr. Smith has reported in his one fatal case. I am not aware of any other report of a similar blow-out but I wonder whether or not the use of nonabsorbable suture material as an interrupted suture may not have contributed to this unfortunate accident postoperatively when the patient became overly distended.

I am extremely glad to see this report, for I'm sure it will stimulate others to familiarize themselves with the indications for this procedure which I believe offers a great deal to those unfortunate people who have repeatedly suffered from small bowel obstruction.

1950-1951 Washington State Medical Association Component Societies

Benton-Franklin Society	President, R. R. DeNicola Richland	D. H. Eckles Richland	Okonagon County Society	President, T. P. Connors Tonasket	Secretary, B. J. Webster Omak
Chelan County Society	President, C. E. Conner Cashmere	Secretary, F. R. Ellis Wenatchee	Pacific County Society, Third Thursday	President, O. R. Nevitt Raymond	Secretary, J. C. Proffitt South Bend
Clallam County Society	President, T. W. Madsen Port Angeles	Secretary, J. J. Fairshier Port Angeles	Pierce County Society	President, J. F. Steele Tacoma	Secretary, G. C. Kohl Tacoma
Clark County Society	President, D. R. Loree Vancouver	Secretary, F. M. Butler Vancouver	Skagit County Society	President, R. R. Rueb Concrete	Secretary, R. M. Hoag Concrete
Cowlitz County Society	President, H. H. Minthorn Longview	Secretary, F. D. Morrison Longview	Snohomish County Society	President, W. V. Meyer Everett	Secretary, R. J. Wescott Everett
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Kitsap County Society	President, H. A. Barner Bremerton	Secretary, F. Rosendale Bremerton	Wallo Walla Valley Society	President, M. W. Tompkins Walla Walla	Secretary, L. O. Carlson Walla Walla
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Lewis County Society	President, G. W. Kling Centralia	Secretary, H. Y. Bell Centralia	Yakima County Society	President, R. D. McClure Yakima	Secretary, W. H. Gray Yakima
Lincoln County Society	President, E. R. Salter Davenport	Secretary, J. E. Anderson Wilbur			

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Book Reviews

Books reviewed in the columns of *NORTHWEST MEDICINE* may be borrowed by any subscriber. Write Mrs. Marylyn McCurdy, acting librarian, King County Medical Society Library, Room 121, Cobb Building, Seattle 1, Wash. The library appreciates, but does not demand, reimbursement for postage.

PHARMACOLOGICAL BASIS OF PENICILLIN THERAPY. By Karl H. Beyer, Ph.D., M.D., F.A.C.P., Director of Pharmacological Research, the Medical Research Division, Sharp and Dohme, Inc., Glenolden, Pa. 214 pp. Price \$4.50. Charles C. Thomas, Springfield, Ill., 1950.

This monograph limits itself for the most part to setting forth exactly what the title indicates, not attempting to cover the antibacterial actions of penicillin, except insofar as they are necessary in discussing the pharmacological background of the drug's action. There are seven chapters in the book, with a concise summary at the beginning of each chapter. This is a format which could well be copied more widely. Throughout the book key sentences and phrases are italicized and graphs and tables illustrate the text. There is a good discussion of the use of Carinamide to elevate blood penicillin levels, and a short discussion on the use of the new drug Benemid. The renal clearance of penicillin is covered thoroughly. References are given at the close of each chapter.

The summaries at the head of the chapters should be required reading for all physicians. This book should be in all medical libraries and should be available to all physicians.

ROBERT W. SIMPSON, M.D.

BLOOD GROUPS IN MAN. By R. R. Race, Ph.D. (Cantab.), M.R.C.S. (England), Director, Medical Research Council Blood Group Research Unit, Lister Institute, London and Ruth Sanger, Ph.D. (London), B.Sc. (Sydney) Medical Research Council Blood Group Research Unit, Lister Institute, London. With a Foreword by Professor R. A. Fisher, F.R.S. 290 pp. Price, \$6.50. Charles C. Thomas, Springfield, Ill., 1950.

The authors are two of several English serologists who have contributed a great deal to our present knowledge of blood groups. This volume concerns itself primarily with the known blood groups and their inheritance; but a great deal of information on Rh antibodies and the methods used in Rh testing is included. All physicians who order blood transfusions and, particularly, obstetricians and pediatricians, could learn how complex a problem they are often called upon to deal with clinically.

The text would be of great help to anyone interested in human inheritance because blood groups are the only characteristics, besides sex, useful in the science of human genetics and mapping of chromosomes. The authors have been very fair in presenting both sides of all controversial serologic problems.

Q. B. DEMARSH

THE BASES OF HUMAN BEHAVIOR. A Biologic Approach to Psychiatry. By Leon J. Saul, M.D., Professor of Clinical Psychiatry, University of Pennsylvania School of Medicine; Psychiatric Consultant, Swarthmore College; Lecturer, Bryn Mawr College. 150 pp. Price, \$4.00. J. B. Lippincott Co., Philadelphia, Pa., 1951.

The content of this book is beamed primarily to medical students as a supplement to their first year courses in biology and physiology. The clarity necessary to such a select audience seems particularly valuable to those of us graduated prior to 1940, whose medical training has largely been devoid of any but descriptive psychiatry.

Particularly valuable to all of us are those areas of the book which explain so aptly the physiobiologic tie-ups between mind and pathology of the body. With disease concepts now firmly psychosomatic in orientation, Dr. Saul's book gives us all an opportunity to supplement our own somatic training. This is a book you can read.

The author leads us to psyche without leaving the microscope and in quite the scientific style and terminology to which we have been accustomed. You will not have to lay this book aside after the second page with such a lament as "why don't these psychiatrists get down to earth?" On the contrary, it will deepen and broaden every technical concept you possess.

B. J. PIPE

DIABETES GUIDE BOOK FOR THE PHYSICIAN. American Diabetes Association, Inc., 79 pp. The American Diabetes Association, Inc., New York, N. Y., 1950.

One million people in the United States are known to have diabetes. At least one million more have the disease and do not know it. It is, therefore, important to recognize these people early and treat them carefully. The Diabetes Guide Book for Physicians was published by the American Diabetes Association with the hope that it would serve as an effective outline in recognizing and treating diabetes. It is not a substitute for the excellent textbooks available, but a guide in dealing with the common problems of diabetes. The book is short, concise and to the point. It is well recognized by the committee on education of the American Diabetes Association that there are many schools of thought in the detailed treatment of diabetes. No attempt is made to discuss these various opinions. However, the plan presented is known to be effective and should meet the need for which it is created; to help the busy general practitioner.

The book is divided into four parts. Part one states the general principles and objectives of treatment and the criteria for the diagnosis of diabetes. Part two discusses dietary regulation and presents a simplified method of dietary calculations based on the idea of "Food Exchanges." This section is particularly helpful, since a little study will enable any busy practitioner to prescribe a proper diabetic diet. Six sample meal plans are given; four for adults and two for juveniles. How to initiate insulin therapy in both the patient with symptoms and without symptoms is described in part three. Use of the new NPH insulin is not described, since its popularity has arisen since publication of the booklet. Essentials of treatment during acute infections, acidosis and during surgery are outlined in part four. This section is clear-cut. It forms a ready refer-

(Continued on Page 800)



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Correspondence

(Continued from Page 756)

raising its own standards and providing better care for the public is proof that it is willing and able to do so when given a free hand. This is shown by the fact that the only doctor of medicine involved in this abortion mess was one who had been previously indicted by the profession and whose license had been removed by the Board of Medical Examiners. Though this board is a legal and official body, it is chosen from men recommended by the state society. This man had been reinstated in the practice of medicine by order of the courts, which is proof that the medical profession does try to clean its house adequately but is interfered with by outside bodies. I think that Governor Sprague should be asked to submit any evidence that he has of a kick-back in fees to doctors referring patients. If this be so, the Medical Society would like to do something about it. This constitutes a breach of ethics about which we can do something actively without fear of criticism or accusation of jealousy.

EDWARD H. McLEAN, M.D.
Oregon City, Oregon

To the Editor:

It is a sad and unrewarding task to attempt to re-educate anyone as lacking in interest and sympathy as the "Editor" from Salem so aptly chastized by the September issue of *NORTHWEST MEDICINE*.

This situation, however, does point up the necessity

for Medicine to "roll up its sleeves" and systematically approach these few delinquents of the fourth estate, armed with facts and figures. Too often our friends at the editorial desk are gladiators carrying on our battle blindfolded for lack of informational ammunition. Printed pamphlets are not enough and must not substitute for personal contact.

We might also add, in passing, how much better would life be if we could but remove all the rotten apples from the professions of medicine, law, news and so forth—ad infinitum.

Sincerely,

L. W. STAUFFER, M.D.
Eugene, Oregon

To the Editor:

We have long come to think of the *Oregon Statesman* as one of our leading journals and that its editorials mold public opinion and have a profound influence for good in our legislative halls. However, although there was some truth in the editorial of July 10, it fell from the *Statesman's* usual factual reporting and high standards of fairness and justice.

I believe we all abhor the abortion racket and the State Medical Society recently passed a resolution commending the district attorney of Multnomah County for his zeal in attempting to clean up the racket. One doctor already was under suspension for practice unbecoming a physician.

Our state societies operate and encourage county societies to operate grievance committees similar to the Alameda Plan, where anyone having a complaint against a doctor can get a hearing by impartial doctors who make every effort to make a just settlement of these differences between the public and the profession. Our malpractice policy is to pay all just claims. The profession is committed to a policy of service to the public and is committed to higher ethics than mere protection of one another. The editor should have known this. As a member of various boards of higher learning in this state, he should have known the difference between chiropractors and physicians and should not have mentioned them in the same breath.

Yes, the *Statesman* has held a high position in Western journalism, but even sometimes the gods may fall.

M. E. CORTHELL, M.D.
Grants Pass, Oregon

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Book Reviews

(Continued from Page 796)

ence for emergency treatment in diabetes. Finally, the physician's responsibility in educating the patient about his disease is stressed.

In summary, the Diabetes Guide Book for the Physician, prepared by the American Diabetes Association, fulfills the need of being a quick reference for the busy doctor to help him prescribe correct diets and insulin and to take care of the common complications of diabetes. Copies of the booklet have been mailed to every doctor who is a member of the American Medical Association. Further copies may be obtained by writing to the American Diabetic Association, 11 West 42nd Street, New York 18, N. Y.

R. H. BARNES

THE CEREBRAL CORTEX OF MAN. A Clinical Study of Localization of Function. By Wilder Penfield, C.M.G., M.D. (Johns Hopkins), B.Sc. and D.Sc. (Oxon.), Hon. F.R.C.S. (Lond.), F.R.S. Professor of Neurology and Neurosurgery, McGill University; Director, Montreal Neurological Institute, and Theodore Rasmussen, M.D., Professor of Neurological Surgery, University of Chicago; Assistant Surgeon, Montreal Neurological Institute. 248 pp. Price, \$6.50. The Macmillan Company, New York, 1950.

In this monograph, which constituted the Lane Medical Lectures at Stanford for 1947, Dr. Penfield has summarized results of his classical experiments on stimulation of the cerebral cortex of man. An effort is made to connect results of the work on man with Sherrington's studies on monkey cortex, and the problems of transferring knowledge from laboratory experimental animals to man are illustrated with authority.

Specific topics discussed include Historical Notes and Methods; Head and Eye Movement; Representation of Autonomic Systems; Vocalization and Arrest of Speech; Secondary Sensory and Motor Representation; Vision; Hearing and Equilibration; Memory. Sensory, Perception and Dreams; Excision of Cortical Regions; General Conclusion.

PROBLEMS IN CEREBELLAR PHYSIOLOGY. By G. Moruzzi, M.D., Professor and Head of the Department of Physiology, University of Pisa, Pisa, Italy, Annual Research Professor of Neurology, Northwest University Medical School, Chicago, Ill. 116 pp. Price \$3.25. Charles C. Thomas, Springfield, Ill., 1950.

G. Moruzzi's "Problems in Cerebellar Physiology" contains a booklet from a series of four lectures given in December, 1948, when the author was an exchange research professor of neurology at Northwestern University Medical School. Being a physiologist—head of the department at the University of Pisa—the monograph is clearly intended for students of neurophysiology and not for those interested in its clinical application. Confined to the anterior lobe, the four chapters deal with cerebellar inhibition and facilitation of postural tonus, inter-relationship with the cerebral motor cortex and finally its influence in the autonomic sphere.

Following a brief historical review, each chapter summarizes the most recent findings up to the end of 1948. A good many data still needed confirmation by that time. Besides presenting the explanations

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and theories of other neurophysiologists the author adds his own impressions and hypotheses, pointing the way to further research in this field. The few illustrations which are presented consist of explanatory tracings from the author's previous papers. The delay of publication of this monograph, more than two years since the original lectures were delivered, is to be regretted in view of the further advances of cerebellar research. R. S. Snider's concise and well-illustrated summary of recent studies of cerebellar anatomy and physiology in the August, 1950, number of the *Archives of Neurology and Psychiatry* offers to those of us more inclined towards clinical interests a far clearer, more readable and up-to-date presentation.

W. W. KLEMPERER

CANCER AS I SEE IT. By Henry W. Abelmann, M.D. 100 pp. Price \$2.75. Philosophical Library, New York, 1951.

This is a somewhat rambling, disconnected account of the author's views regarding the infectious nature of cancer. The infectious agent is variously referred to as a germ, virus, mold, fungus, and parasite. The book contains numerous misstatements, half-truths, and statements regarded by the author as facts which at best are only theoretical in the light of present scientific knowledge.

Dr. Abelmann speaks freely of his wide experience with cancer, and his extensive research work in the field of the infectious etiology of cancer. He draws conclusions based on his observations and experiments, but gives no detailed information regarding the nature or extent of these experiments, which gives the reader the impression of an unscientific approach to the problem. A perusal of the Surgeon General's Index-Catalogue prior to 1936, and of the *Index Medicus* since 1936 fails to reveal a single reference under the author's name.

This reviewer cannot recommend the book, and feels that it contributes nothing to scientific literature.

G. E. TOOLEY

HEMODYNAMICS IN FAILURE OF THE CIRCULATION. By W. B. Youmans, M.D., Ph.D., Professor of Physiology, Department of Physiology, University of Oregon Medical School, Portland, Oregon, and A. R. Huckins, M.S., M.D., Research Assistant, Department of Physiology, University of Oregon Medical School, Portland, Oregon. 71 pp. Price \$2.75. Charles C. Thomas, Springfield, Ill., 1951.

This book states and discusses the basic physiological principles of the circulation of the blood, both normal and the various types of heart failure. The points made are well illustrated by simplified diagrams. According to the authors, it is written primarily for (1) Medical students, (2) Those who have not had an opportunity to do systematic reading on the subject, (3) Those who wish to review the subject in light of basic physiological facts, and (4) Those who are familiar with the subject but may be interested to see which of the various controversial interpretations of congestive failure the authors have chosen to support.

The authors have fulfilled their purpose and this brief monograph can be highly recommended.

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*Baumgartner, L.: Wider Horizons for Children; The Mid-century White House Conference and Children's Nutrition, J. Am. Dietet. A. 27:281 (Apr.) 1951.

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*Reference: MacBryde, C. M., et. al., *A New Synthetic Estrogen*, I.A.M.A., 123: 261: 264-(10-2) 43.



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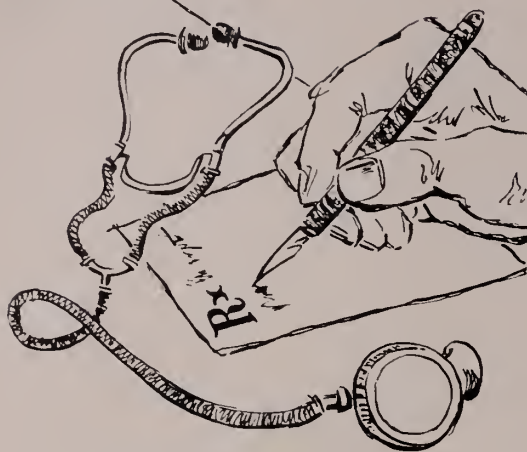
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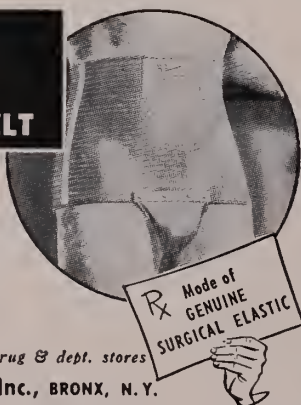
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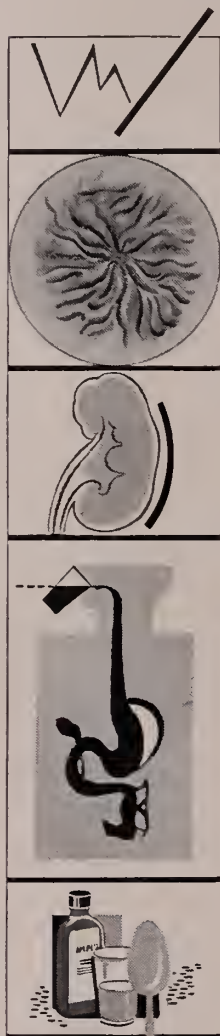
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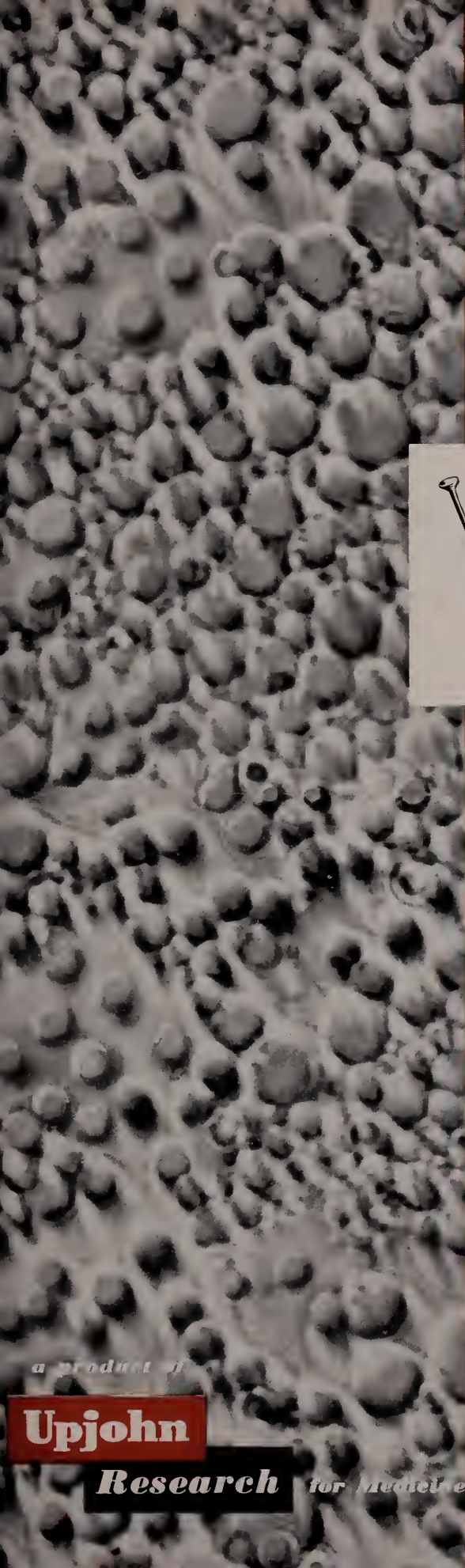


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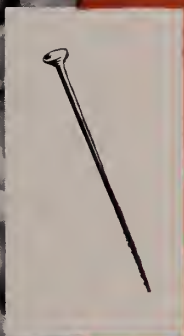
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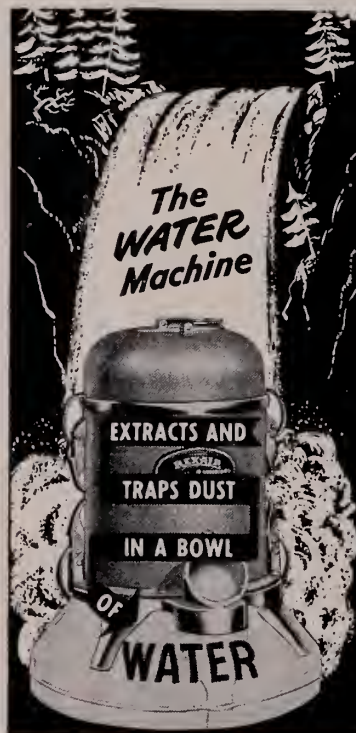
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- American Medical Association**.....Chicago, 1952
Clinical Session, Los Angeles, Dec. 4-7, 1951
- Oregon State Medical Society**.....Portland, Oct. 10-13, 1951
President, W. J. Weese Secretary, R. F. Miller
Ontario Portland
- Washington State Medical Association**.....Sept. 13-17, 1952
President R. A. Benson Secretary, Bruce Zimmerman
Bremerton Seattle
- Idaho State Medical Association**.....Sun Valley—June 15-18, 1952
A. M. Popma Secretary, R. S. McKean
Boise Boise
- Alaska Territorial Medical Association**.....Anchorage—June, 1952
President, H. Romig Secretary, W. P. Blanton
Anchorage Juneau

PERIODICAL SOCIETY MEETINGS

NORTHWEST

- North Pacific Society of Neurology and Psychiatry**.....Seattle, 1952
President, S. N. Berens Secretary, R. A. Coen
Seattle Portland
- North Pacific Pediatric Society**
President, Gordon Matthews Secretary, S. G. Babson
Vancouver, B. C. Portland
- North Pacific Surgical Assn.**.....Vancouver, B. C., Nov. 16-17, 1951
President, S. F. Herrmann Secretary, J. A. Duncan
Tacoma Seattle

OREGON

- Central Willamette Society**.....Second Thursday
President, W. W. Ball Secretary, F. R. Asbury
Corvallis Corvallis
- Oregon Academy of Ophthalmology and Otolaryngology**—Third
Tuesday, Old Heathman Hotel, Portland
President, R. S. Fixott Secretary, G. E. Chamberlain
Portland Portland
- Oregon Pathologists Association, Second Wednesday**—Portland
President, V. D. Sneeden Secretary, J. E. Nohlgren
Portland Portland
- Oregon Radiological Society**—Second Wednesday—University
Club, Portland
President, Arthur Hunter Secretary, J. R. Raines
Portland Portland
- Portland Academy of Pediatrics**.....First Monday
President, S. G. Babson Secretary, Edward Rector
Portland Portland
- Portland Surgical Society**.....Lost Tuesday
President, J. M. Roberts Secretary, J. W. Nadal
Portland Portland
- Southern Oregon Medical Society**.....Roseburg—May 13, 1952
President, A. M. Johnson Secretary, F. C. Adams
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WASHINGTON

- Washington State Obstetrical Society**.....1952
President, E. G. Layton Secretary, L. B. Donaldson
Seattle Seattle
- Puget Sound Academy of Ophthalmology and Otolaryngology**
.....Third Tuesday—Seattle or Tacoma
President, J. F. Tolan Secretary, Willard Goff
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- Seattle Academy of Surgery**.....Third Friday
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- Seattle Gynecological Society**.....Third Wednesday
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- Seattle Pediatric Society**.....Fourth Friday
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- Seattle Psychoanalytic Study Group**.....First Thursday
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- Seattle Surgical Society**.....Second Friday
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	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro- intestinal System	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio- vascular System	Rapid heart rate Peripheral vaso- constriction	Slow heart rate Vasodilatation
Functional Manifesta- tions	Palpitation Tachycardia Elevated blood pressure Dry mouth and throat	Heartburn Nausea-vomiting Low blood pressure Colonic spasm

The data here tabulated is from references 3,4,5,6,7, given below.

When the clinical picture is suggestive of functional disorder, the diagnosis is supported by the presence of the following indications of autonomic lability:

- Variable Blood Pressure
- Body Temperature Variations
- Changing pulse rate
- Deviations in B. M. R.
- Exaggerated Cold Pressure Reflex
- Oculo-Cardiac Reflex Abnormalities
- Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relieving the somatic disturbance to prepare the patient for psychotherapy*; 2) guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

*Drug treatment using adrenergic and cholinergic blocking agents in conjunction with sedatives. 8,9,10.

1. Ebaugh, F.: Postgrad. Med. 4: 208, 1948. 2. Wilbur, D.: J.A.M.A. 141: 1199, 1949. 3. Williams, E. and Carmichael, C.: J. Nat'l. Med. Assoc. 42: 32, 1950. 4. Goodman, L. and Gilman, A.: The Pharmacological Basis of Therapeutics, The Macmillan Co., 1941. 5. Katz, L. et al: Ann. Int. Med. 27: 261, 1947. 6. Weiss, E. et al: Am. J. Psychiat. 107: 264, 1950. 7. Alvarez, W.: Chicago Med. Soc. Bulletin, 581, 1950. 8. Rakoff, A.: A Course in Practical Therapeutics, Williams and Wilkins, 1948. 9. Karnosh, L. and Zucker, E.: A Handbook of Psychiatry. C. V. Mosby Co., 1945. 10. Harris, L.: Canad. M.A.J. 58: 251, 1948.

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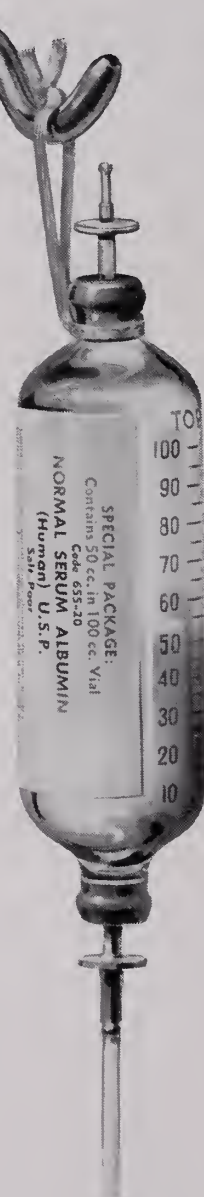
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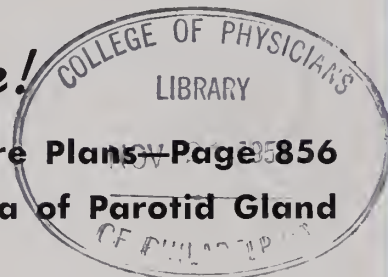
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Vol. 50

NOVEMBER, 1951

No. 11

Attention, Please!



Western Conference of Prepaid Medical Care Plans—Page 856

**Pleomorphic Adenoma and Adenocarcinoma of Parotid Gland
—Sinclair**

Effect of Pregnancy on Mortality Rate in Tuberculosis—Murphy

Oregon State Convention Pictures—Pages 864, 865

Medical Economics News—Washington Section

Poliomyelitis in Adults—Bakke and Haviland

Contents—See Page 830

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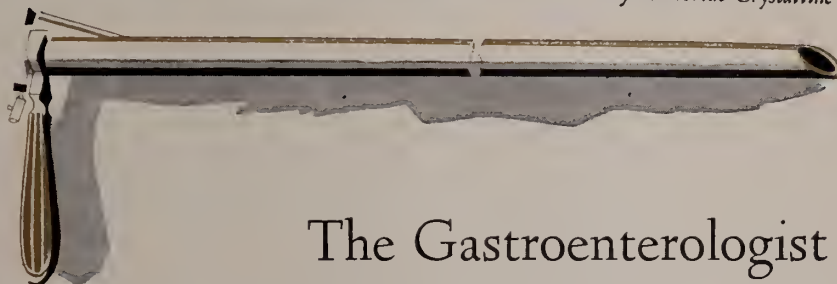
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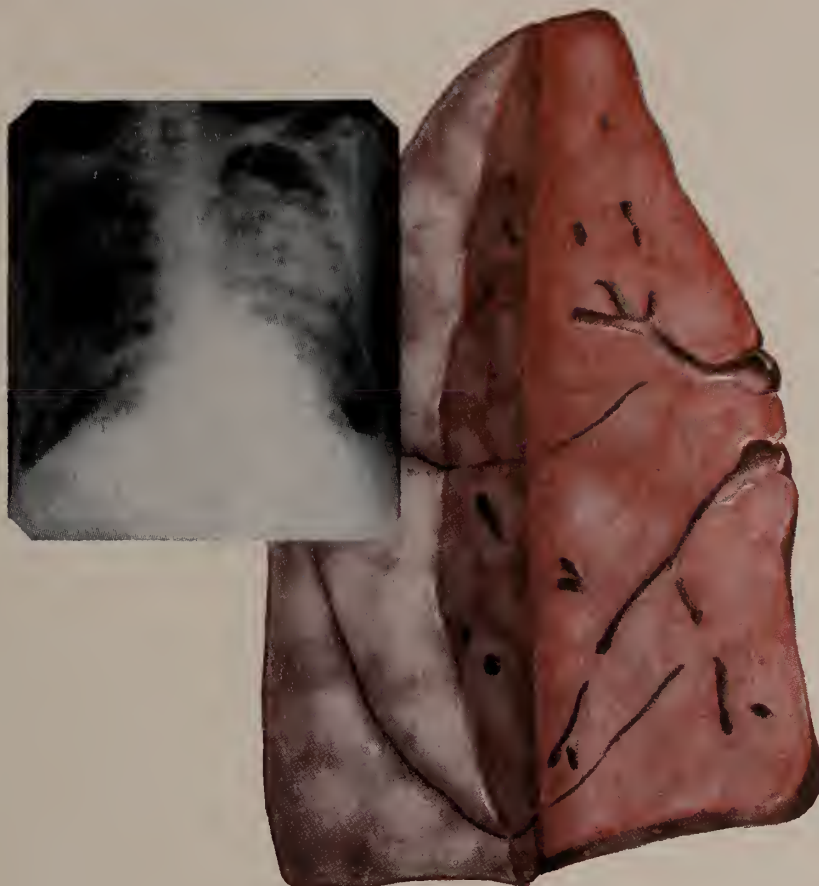
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*Potterfield, T. G., and Starkweather, G. A.:
J. Philadelphia General Hosp. 2:6 (Jan.) 1951.*

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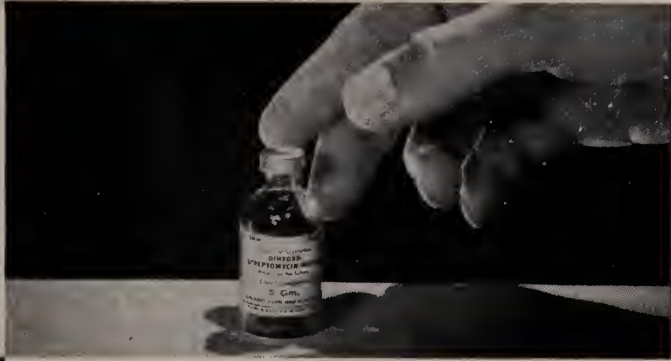
ARE YOU WORTH ONE CIGARETTE A WEEK? A visitor from England, A. Lawrence Abel, who is president of the London area of the British Medical Association, says that 20 cigarettes cost his countrymen 49 cents. One cigarette is thus worth 2½ cents. Out of the weekly contribution to national health insurance the British family physician receives less than 3 cents. Thus, Dr. Abel concludes that physician's service in England is worth about one cigarette a week.

FREEZE FROM FLORIDA AS FINE AS FRESH. Citrus growers of Florida are proud of their product. Especially their frozen orange juice. They may well be proud of the sales record which shows that frozen concentrated orange juice now accounts for 35 per cent of all frozen food business exclusive of ice cream. Apparently public acceptance of these products is well founded. Not only is flavor excellent but vitamin C content of reconstituted juice has been shown fully equal to that of fresh juice. Additional nutritional factors came to light in one research study when it was found that inositol content was quite high. Final seal of approval in use of frozen orange juice concentrates came when the Council on Foods and Nutrition of the A.M.A. approved them without reservation.

VA WANTS BOMB-PROOF HOSPITALS. Veterans' Administration plans to accept bids this fall for five hospitals built to withstand attack by atomic bombs. They are talking in terms of windowless concrete walls and roofs at least a foot thick. Washington, D. C., and Cleveland have been selected for 500-bed general hospitals. The other three will be 1,000-bed psychiatric institutions. One would be at Cleveland and the others at San Francisco and Los Angeles. Just off-hand we would say that it ought to be cheaper to build them where atomic attack would be considerably less likely. Having flown across the country a few times we have seen quite a few spots not particularly attractive to bombardiers, where there is still room for hospitals.

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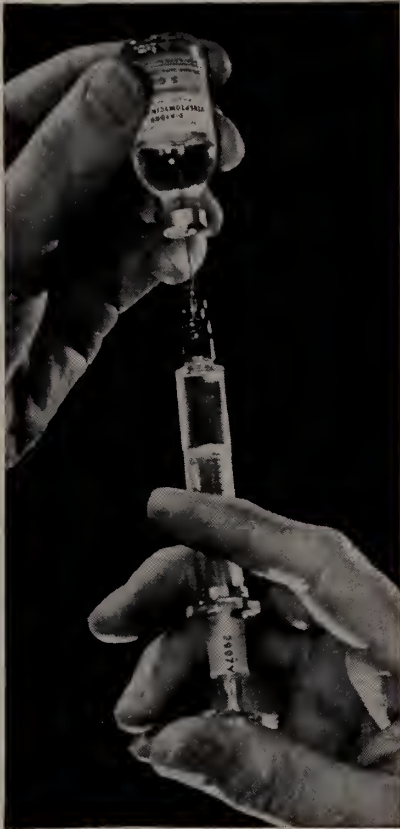
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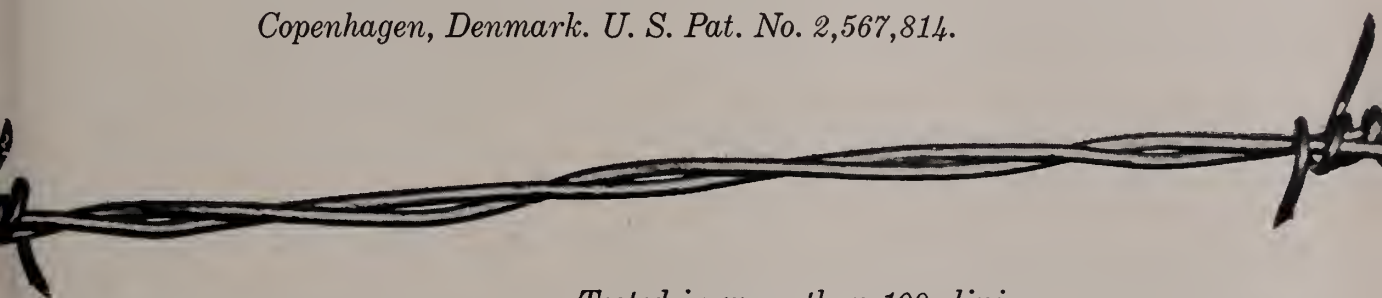
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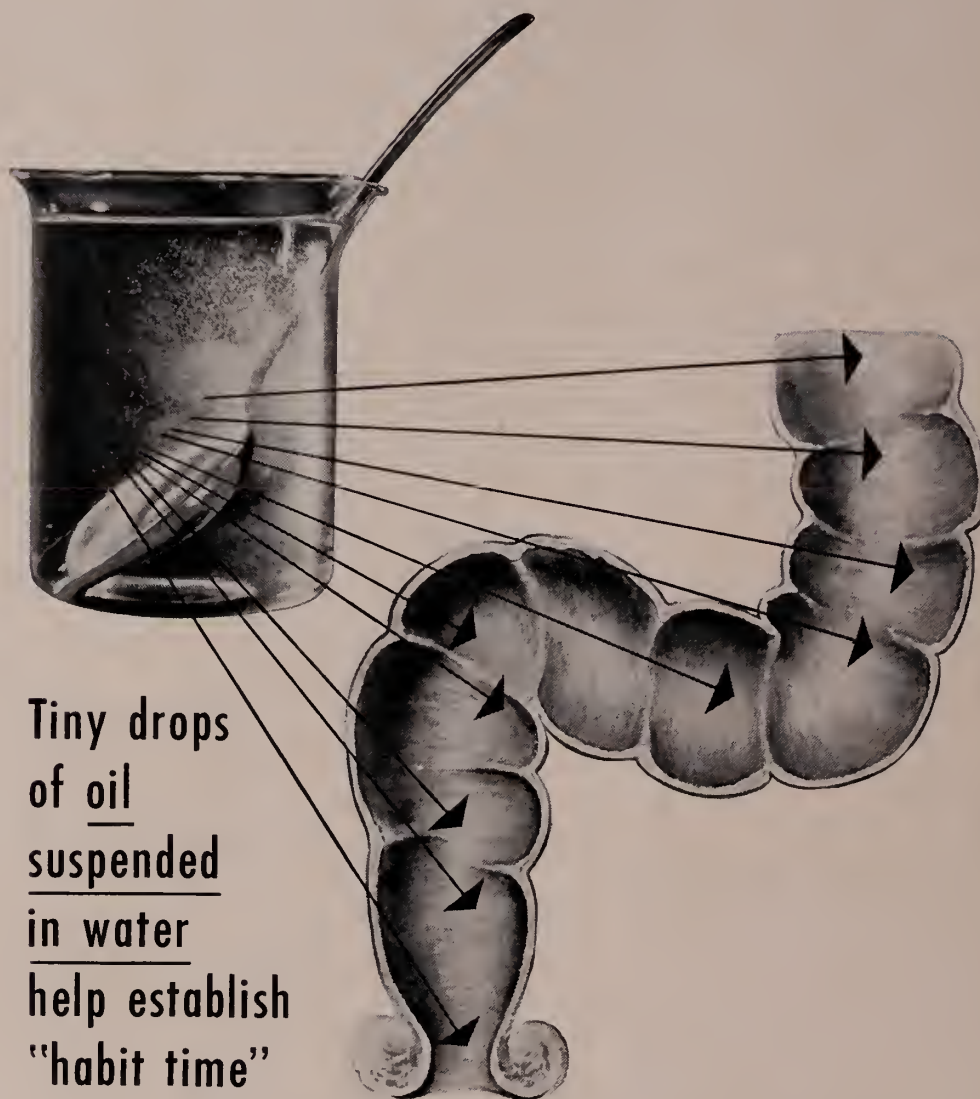
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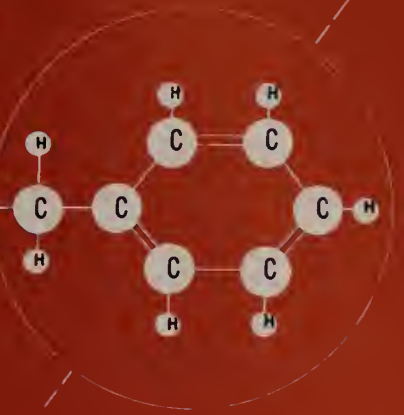
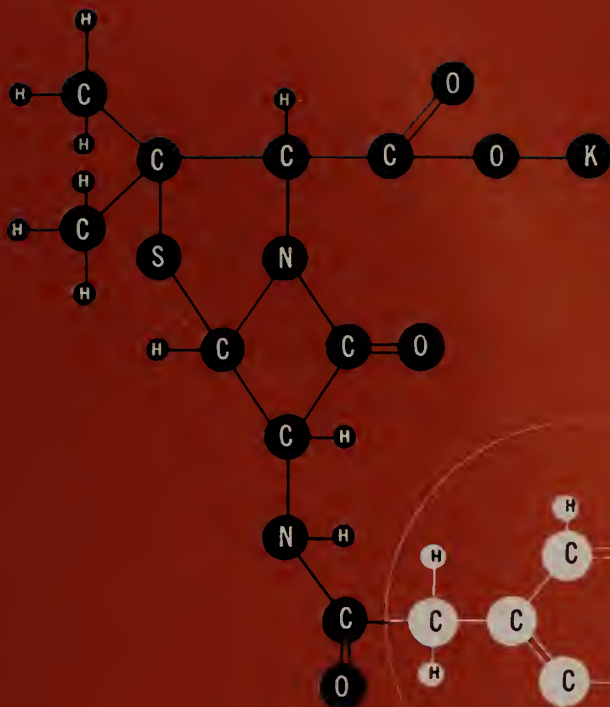
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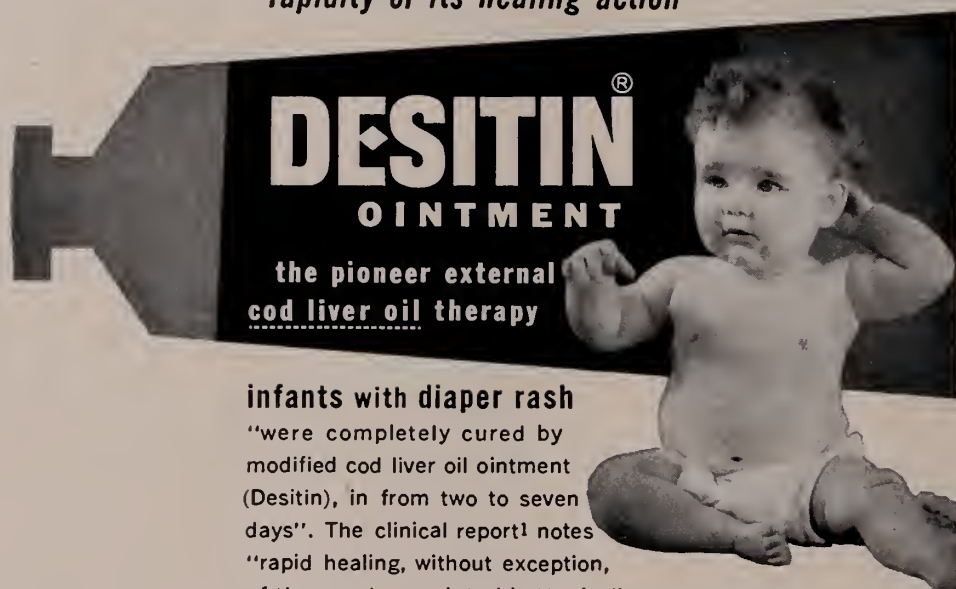


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1. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.

NORTHWEST MEDICINE

VOL. 50, No. 11

NOVEMBER, 1951

\$5.50 per Year

EDITORIALS

Whopping Attendance Smashes 10-Year Record

Oregon's 77th annual session, concluded at Portland last month, was the best ever held by the Oregon State Medical Society. It qualified for the superlative in many respects. A whopping increase of more than one third smashed a ten-year record of registration. Best previous was the Portland meeting of 1941. Meetings at Portland in 1947 and at Timberline Lodge in 1938, both notable for heavy registration, were left far behind.

Several factors contributed to interest in this meeting. One was the honor given to Clyde Foley in celebration of his twenty-five years of service to the Society. Another was the quality of the program, linking the Sommer Memorial Lectures to the annual session. Not to be discounted was advance publicity given the meeting in the *Bulletin of the Multnomah County Medical Society* and in *NORTHWEST MEDICINE*.

Like most useful ideas, union of the Sommer Lectures and meeting of the Society was so well accepted that one was inclined to ask why it had not been thought of before. Had Dr. Sommer been able to look in upon some of the sessions provided by his gift to medical education he should have been gratified, indeed. Presentations of Professor F. H. Bentley of Newcastle-on-Tyne, Charles A. Janeway of Boston and Virgil S. Counsellor of the Mayo Clinic were heavily attended and well received. The committee composed of Frank Menne, Ralph Fenton, Eugene Rockey and Don Trueblood chose its lecturers well in carrying out the stipulation of Dr. Sommer. He specified that money he left in perpetual endowment be used to bring to medical students and practitioners of the Northwest thoughtful discussions of current knowledge.

John Cline, president of the American Medical Association, also contributed to the success of the meeting. His discussion of current problems at the banquet Friday evening was a typical presentation by one of the most articulate of medical men. By way of something unusual Dr. Cline also gave an excellent discourse on breast diseases as part of the scientific program Thursday evening. It is refreshing to hear an officer of the national body discuss something other than organizational affairs.

Arrangements for the meeting were much better than for any previous session. In certain respects, however, there is still room for improvement. Exhibitors would have been much better satisfied had the registration booth been placed in the main exhibition hall. This would have encouraged more visiting at the displays. It would also have been relatively easy to have routed traffic to and from the scientific sessions through the exhibits. Slight inconvenience experienced by those in attendance is more than made up by the good will thus obtained from exhibitors. They deserve every break they can be given. Their fees for space pay most of the costs of the meeting, just as their fees for advertising pay most of the costs of publishing a medical journal. Income from this source to the Oregon State Medical Society this year doubled the best previous record.

Sessions in the auditorium at the medical school introduced another of the less desirable features of the meeting. The school is relatively isolated and difficult to reach by out-of-city visitors who do not arrive by private transportation. It was even difficult to find by some, unfamiliar with Portland streets, who drove their own cars.

Actually, there is some question as to the value of evening sessions. Physicians are a hard-working lot and accustomed to arising early. House of Delegate sessions at Oregon meetings begin at 7 o'clock in the morning. An element of exhaustion is quite likely to enter the picture for those who attend an almost continuous meeting until 10 or 11 in the evening.

Sessions of the House of Delegates were efficiently conducted by Arch O. Pitman. No important controversy arose. Committee reports, resolutions and other items of business were discussed freely and acted upon with unanimous agreement in nearly every case.

Mrs. W. W. Baum of Salem, president of the Woman's Auxiliary, led sessions of that organization. Meetings were exceptionally well attended and much interest was shown. Mrs. Baum had as special guests both Dr. Cline, president of A. M. A., and Mrs. Harold F. Wahlquist of Minneapolis, president

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of the Woman's Auxiliary to the American Medical Association. Mrs. Wahlquist spoke at the Friday forenoon session while Dr. Cline addressed the group at luncheon meeting on Thursday.

Highlight of the meeting was the annual banquet held at the Multnomah Hotel Friday evening. This was a special occasion with Clyde Foley, executive secretary of the Oregon State Medical Society, receiving the honors. Several hundred special guests, including Governor McKay and Mayor Lee, swelled total attendance to new high records. Wide popularity of Mr. Foley was attested by the fact that it was necessary to hold an overflow meeting which filled the Junior Ballroom of the hotel and still there was demand for seats which could not be met.

At the final session in the Commandery Room of the Masonic Temple the following officers were elected:

President, Blair Holcomb, Portland
President-Elect, J. D. Rankin, Coquille
First Vice-President, John G. P. Cleland, Oregon City
Second Vice-President, Carl H. Phetteplace, Eugene
Third Vice-President, Thomas F. Farley, Klamath Falls
Secretary, Robert F. Miller, Portland
Treasurer, Robert W. Kullberg, Portland

Speaker of the House of Delegates, A. O. Pitman, Hillsboro

Vice-Speaker of the House of Delegates, J. V. Straumfjord, Astoria

Delegate to the A. M. A. (2-year term ending 1953), W. W. Baum, Salem

Alternate Delegate to the A. M. A. (2-year term ending 1953), Werner E. Zeller, Portland

Councilors (3-year term ending 1954):

Second District—Blair J. Henningsgaard, Astoria

Fifth District—Dwight H. Findley, Medford

Seventh District—T. L. Hyde, The Dalles

Councilor-at-Large—Marion Reed East, Portland

Karl Martzloff was nominated by the House to the Board of Trustees of NORTHWEST MEDICINE.

Seattle Host to Western Medical Plans

On November 9 and 10 Seattle will play host for the first time to the Western Conference of Prepaid Medical Care Plans, convening for its annual fall meeting.

The organization was born during a regional American Medical Association meeting in Chicago in 1948, when the proceedings convinced representatives that the western area's development in the prepaid medical care field was far advanced over that of the east. They felt there was immediate need for all western plans to work together to keep advantages gained and to continue development along sound lines.

A medical Rip Van Winkle, awakening now after slumbering the past 20 years, would find that medical practice is startlingly different as a result of the vast change wrought by the social, economic and political developments of the period. An infant with an uncertain life expectancy 20 years ago, prepaid medical care has burgeoned so tremendously in this period that almost half the entire population of the nation has such coverage and the practice of every doctor in the country has in some way been affected by it.

Fortunately, doctor-organized and operated plans

are in dominance in the west and provide a scope of care to the subscriber and benefit to the doctor unequalled in any other comparable area. Physicians of the western United States and Canada deserve much credit for the manner in which they have met the problem and for providing such a wide range of prepaid care for so many people—though there is much in prepaid medicine that is not ideal for the physician.

The physicians and bureau managers meeting here next week represent some 15,000 physicians who participate in the plans and more than two million people who subscribe to them. They will spend two days exchanging ideas, analyzing problems and comparing services offered. They will consider improvements and will spend much time discussing criticisms and desires of subscribers as well as the best interests of physicians.

These men are to be congratulated on what they have accomplished, on the goals they have set and on the manner in which they are seeking to improve the medical care plans in western United States and Canada. As the representatives of 15,000 doctors and over two million subscribers they have a large and serious responsibility.



Many Records Broken

From banquet attendance to news coverage the 77th annual meeting of Oregon State Medical Society was a record smasher. Portland newspapers gave far more attention to this meeting than to any previous session. Total lineage was 309 column inches of which 22 inches appeared in editorial departments. It is significant that editors of the two leading Portland papers were sufficiently interested to make comments. One wrote a particularly fine tribute to Clyde Foley.

Total registration at the meeting was 507, the best previous record having been made at Portland, in 1941, when 377 registered. Of the registrants 450 were from Oregon. This represents 32 per cent

of the membership. Thirty-nine were from Washington, six from Idaho, four from California and two from Montana. One registrant came from each of the following: Iowa, Indiana, Minnesota, Massachusetts.

Annual banquet attendance record was more than doubled. Best previous was 300 at Portland in 1947. This one was attended by 615 persons of whom 197 were community leaders and their wives.

Technical and scientific exhibits also broke records. There were 51 technical exhibits, far more than the previous high of 34 at Gearhart last year. Scientific exhibits numbered 35, a jump from 1950, when there were 27.

Let's Stay Out of Trouble

Basic principles never change.

Einstein increased our understanding of the laws of gravity, but he couldn't change them. Apples will fall from trees as long as there are apples. The aviator flies in strictest conformity with the laws of gravity, or he falls—still in strictest conformity with them.

The basic requirements of medical practice are equally inescapable. We conform to them or, like the aviator, we mess up the landscape and the remains usually aren't worth bothering about.

These requirements were long epitomized as free choice of physicians, and freedom from third party interference.

Free choice of physician meant the right to choose and to change at any time, the physician to whom one entrusts his well-being. It is merely a corollary of the far more fundamental right of every individual to reject all medical care except what he chooses to accept.

Freedom from third party interference meant that the physician must be solely and directly responsible to his patient. It recognized that while standardized care may keep a population of slaves at maximum productivity, only the freely exercised judgement of a physician who is directly responsible to his patient can meet the medical needs of a free man.

Responsibility and control are by their nature inseparable. He who holds the purse-strings calls the tune.

Techniques of flying a plane are unlike those of driving a buggy. Techniques of providing modern medical care in an air-age society must be unlike those of the horse-and-buggy doctor. But the new techniques must still conform to basic principles.

When plans for the collective payment of medical expense violate these principles they destroy the very thing they were intended to preserve. Both physicians and patients then acquire the status of slaves—well-fed slaves, perhaps, but nonetheless slaves.

We are all aware by now that prepayment plans require rules and regulations for both physician and patient. We have believed, however, that if the individual doctors can control the plan instead of being controlled by the plan, third party interference can virtually be avoided. We have staked our professional existence, and the rights of our patients, on that belief. We have recognized this as a gamble, a dangerous gamble; but we have thought it less dangerous than opposing the propaganda for prepayment.

We have taken this gamble in the hope of saving, not for the purpose of destroying, the practice of medicine. The result, however, will be the destruction of medical practice unless the doctors can retain such control as will prevent the plans from introducing third party interference between the doctor and his patient.

This means that policies of the plans be dictated by the individual doctors—not by some representative of the doctors' interests. It means, at the very least, that if the practice of medicine is to be preserved, government of the plans must be of town-meeting type rather than republican type. It also means that there must be complete local autonomy of the plans. Nothing less will serve.

There can be full cooperation between plans, but only of a completely voluntary nature. Any trace of centralized control means the end of a noble profession.

ORIGINAL ARTICLES

Poliomyelitis in Adults in Seattle in 1949

JOHN L. BAKKE, M.D. and JAMES W. HAVILAND, M.D.*

DURING 1949 there were ninety-two cases of poliomyelitis reported in Seattle. During this period the King County Hospital admitted sixty patients with poliomyelitis to the pediatric service and sixty patients to the medical service. The latter group is the basis of this report. Fifty-seven of the sixty patients were under the direct daily observation of one of the authors (John L. Bakke), who was Resident in Medicine.

CLASSIFICATION AND MORTALITY

The paralytic cases are divided into spinal and bulbar types. The bulbar group is further divided into the simple bulbar, upper cranio-bulbar, upper cranio-bulbo-spinal, and bulbo-spinal as shown in Table 1.† The non-paralytic group is further discussed under differential diagnosis below. In all paralytic patients, weakness persisted for at least two weeks after admission. However, many patients subsequently regained normal strength. Since the follow-up did not extend beyond the isolation period of two weeks in all cases, no attempt will be made to classify patients according to residual paralysis.

Three of the sixty patients died of poliomyelitis, giving a mortality of 5 per cent, which is consistent with 5.9 per cent reported for 235 cases over thirteen years of age in the entire state during this period. It will be noted that all three deaths occurred in individuals with bulbar involvement and all three were males.

SEX

Males predominated in paralytic cases (Table 2). Sixteen of the twenty-three bulbar cases were in males (74 per cent); the three deaths were in males. It is of interest to compare these figures with those for the entire state. In the group of 238 patients over 12.5 years of age, twelve of the fourteen deaths were males (86 per cent). In the group of 352 patients under 12.5 years, eleven of the eighteen deaths were in males. Worse prognosis for life for males was noted also in the 1948 San Diego epidemic.²

*From the Department of Medicine, University of Washington School of Medicine and the King County Hospital, Seattle, Wash.

†This classification was taken, with slight modification, from Minnesota Poliomyelitis Research Commission (The Bulbar Form of Poliomyelitis: Diagnosis and the Correlation of Clinical with Physiologic and Pathologic Manifestations, J. A. M. A., 134:757-762, June 28, 1947.)

1. Footnote deleted.

2. Blum, H. L., Chiapella, W. C. and Lessem, A. M.: The 1948 Epidemic of Poliomyelitis in San Diego County, California, Stanford M. Bull., 7:169-179, Nov., 1949.

AGE

Very few paralytic cases occurred in the group over thirty-three years of age (Table 3). Only three patients in our series with paralytic poliomyelitis and only twenty-two in the state series of 590 were over the age of thirty-three. By contrast both cases of mumps meningo-encephalitis which occurred during this epidemic were over the age of thirty-three. (See below.)

TABLE 1

TABLE I CLASSIFICATION AND MORTALITY							
Type	Non-Paralytic	Paralytic					Total
		Spinal		Bulbar			
			Simple	CR-B	CR-B-Sp	B-Sp	
Number	18	19	15	1	2	5	60
Deaths	0	0	0	1	1	1	3

TABLE 2

TABLE 2				
Sex	SEX DISTRIBUTION		Total	
	Non-Paralytic	Paralytic		
		<i>Spinal</i>	<i>Bulbar</i>	
Male	5	11	16	32
Female	13	8	7	28
Total	18	19	23	60

TABLE 3

TABLE 3				
Age	AGE DISTRIBUTION			Total
	Non-Paralytic	Paralytic		
		<i>Spinal</i>	<i>Bulbar</i>	
13 to 22 years	5	7	5	17
23 to 32 years	6	10	17	33
33 years plus	7	2	1	10
Total	18	19	23	60

RACE

All patients were white, which is of note since other patients in this hospital include a significant number of Negroes, Indians and Japanese—racial groups reported to have a low incidence of poliomyelitis in adulthood.

PREGNANCY

It is the general consensus that incidence of poliomyelitis in pregnant women exceeds that in the population at large. Furthermore, they are more susceptible to bulbar paralysis.³⁻⁵ In our series,

3. Aycock, W. L.: Acute Poliomyelitis in Pregnancy; Its Occurrence According to Month of Pregnancy and Sex of Fetus. New England J. Med., 235:160-161, Aug. 1, 1946.

4. Blum, Chiapella and Lessem: op. cit.

5. Taylor, E. S. and Simmons, J. M.: Acute Anterior Poliomyelitis in Pregnancy. Am. J. Obst. & Gynec., 56:143-151, July, 1948.

there were eleven female patients over fifteen years of age with the paralytic type of poliomyelitis. Three of these were pregnant—three, six and seven months respectively. Each had bulbar paralysis. Three of seven women of childbearing age with bulbar palsy were pregnant.

PREVIOUS SURGERY

Although debated by some, it seems fairly well-established that tonsillectomy does predispose to poliomyelitis, especially the bulbar form.^{6,7} Three of our patients with bulbar paralysis had had operations. One had tonsillectomy sixteen days prior to paralysis. A second was subjected to maxillary antrotomy fourteen days prior to paralysis. A third had a dental extraction four weeks prior to paralysis. In each case paralysis was limited to the palate and other muscles of deglutition. Also of speculative interest was a patient who developed spasm and moderately severe paralysis limited to the right hip and leg twenty days following appendectomy.

PRODROME

Horstmann⁸ recently reported that "the diphasic, 'dromedary' course was common in young children and rare in individuals over fifteen." She found that antecedent headache, fever, sore throat, anorexia or vomiting decreased from 35 per cent in the 2-4-year age group to 10-12 per cent in the group over 15 years of age. In the present series 14 per cent of the patients (two spinal and four bulbar) with paralytic poliomyelitis gave clear-cut history of a prodromal episode of two or three days' duration during the week or two prior to paralysis. Three of the eighteen non-paralytic cases also reported a prodrome.

SYMPTOMS

Symptoms of headache, stiff neck, malaise and aching of muscles, particularly those of the back and thighs, occurred in virtually all sixty patients (Table 4). Vomiting occurred in all but two of the bulbar paralysis patients but in only half of the other groups. Constipation was virtually limited to those with actual paralysis, suggesting that this symptom may result from damage to the visceral motor neurons in the spinal cord rather than to local intestinal or systemic factors. Diarrhea as part of the prodrome was noted infrequently. Urinary hesitancy and retention were encountered in over half of the patients with spinal paralysis and, in several instances, in-dwelling catheters were required for a week or more. This high incidence is frequently overlooked but is reported.^{9,10} Recovery

of sphincter function was complete in all these patients. Paresthesias were complained of in 16 per cent and were especially severe in several patients who later developed marked spinal paralysis.

Mental disturbances dominated the clinical picture of eight (21 per cent) of the patients with paralytic symptoms. These were frequently severe, including visual and auditory hallucinations of a frightening character, even in patients who had no evidence of anoxia or respiratory distress. Careful investigation by a psychiatrist was carried out in three of these patients. A formulation and therapeutic suggestions will be made in the discussion to follow.

PHYSICAL FINDINGS

Muscle examinations by the physical therapy department and orthopedic surgeons revealed that fourteen of the nineteen patients with spinal paralysis had predominance of paralysis on the right side and three of five patients with cranio-bulbar paralysis had predominance of weakness on the dominant side. This includes one left-handed truck driver whose palsy was predominantly in his left arm. Two other patients had no detectable difference in weakness of the two sides.

TEMPERATURE

One-fourth of the patients were afebrile throughout their hospital stay even though they reported feverishness, chilly sensations and shaking chills prior to admission. Higher initial temperatures tended to occur in bulbar palsy cases (Table 5).

TABLE 4

SYMPTOMS

Symptoms	Non-Paralytic	Paralytic		Total
		Spinal	Bulbar	
Malaise and Aching....	17	18	23	58
Headache	18	17	22	57
Stiff Neck	18	16	20	54
Vomiting	10	9	21	40
Constipation	1	9	6	16
Urinary Retention....	2	10	3	15
Delirium or Stupor....	4	4	5	13
Paresthesias	4	3	4	11

TABLE 5

TEMPERATURE

Temperature	Non-Paralytic	Paralytic		Total
		Spinal	Bulbar	
Normal Temperature	8	6	4	18
99.5 F. (37.5 C.) to 103.1 F. (39.5 C.)	9	12	13	34
Over 103.1 F. (39.5 C.) during first 48 hours of hospitalization....	1	1	6	8
Total	18	19	23	60

LABORATORY DATA

Leukocytosis was infrequent in the non-paralytic group but occurred in one-third of those with paralysis. Initial spinal fluid cell count tended to be lower in the bulbar group but in several instances there was predominance of polymorphonuclear forms. Highest cell count (590 lymphocytes per cu.

6. Aycock, W. L.: Tonsillectomy and Poliomyelitis; Epidemiologic Considerations. *Medicine*, 21:65-94, Feb., 1942.
7. Faber, H. K.: Tonsillectomy and Poliomyelitis (correspondence). *J. A. M. A.*, 139:249, Jan. 22, 1949.
8. Horstmann, D. M.: Clinical Aspects of Acute Poliomyelitis. *Am. J. Med.*, 6:592-605, May, 1949.
9. Guyton, A. C.: Reaction of the Body to Poliomyelitis and Recovery Process. *Arch. Int. Med.*, 83:27-47, Jan., 1949.
10. Lawson, R. B. and Garvey, F. K.: Paralysis of Bladder in Poliomyelitis. *J. A. M. A.*, 135:93-94, Sept. 13, 1947.

mm.) was recorded in a non-paralytic case which subsequently was demonstrated to be mumps and was therefore eliminated from this table.

It was of note that 70 per cent of the non-paralytic and 75 per cent of the paralytic patients had normal spinal fluid protein on all examinations. Protein rose over 100 mg. per 100 cc. in four of the non-paralytic group. By contrast, this elevation was noted in only two patients with paralytic poliomyelitis (Table 6).

TABLE 6
LABORATORY DATA

Laboratory Data	Non-Paralytic	Paralytic	
		Spinal	Bulbar
Peripheral WBC (on admission):			
5,000 to 10,000	15	12	16
Over 10,000	3	7	7
Cerebrospinal Fluid WBC (maximum elevation):			
Under 10	1	0	3
10-99	7	8	12
100-199	4	5	6
200-299	2	3	2
300-399	1	2	0
400-499	2	1	0
500-599	1	0	0
Cerebrospinal Fluid Protein (milligrams per 100 cc.)			
Under 50 (normal)	12	16	15
50-100	2	2	7
Over 100	4	1	1
Electrocardiogram			
Abnormal/Normal	1/2	2/4	5/6
Total Cases	18	19	23

ELECTROCARDIOGRAPHIC ABNORMALITIES AND MYOCARDITIS

In view of known myocardial involvement,^{11,12} it is unfortunate that electrocardiograms were not taken routinely but tracings in thirteen showed that one was definitely normal, six were probably normal, three were borderline and three (all in the bulbar group) were definitely abnormal, that is, showed negative and diphasic T1, -2, 4 or R-T segment abnormalities or both. Elevated R-T segments in one patient's tracing were interpreted as characteristic of pericarditis. One patient, without other evidence of heart disease, still had abnormal T waves eight months later.

In two cases careful search was made for myocarditis on postmortem examination. One showed no evidence of inflammation, but the other had a dilated, but not hypertrophied heart, which on microscopic examination revealed slight separation of fibers which might be called edema. At wide intervals, comprising less than 1 per cent of the total tissue, there were small regions where there were

focal collections of inflammatory cells. This was not strictly a normal picture but did not represent any significant myocarditis. This patient was autopsied within a few hours after death on the eighth day of his illness. In an unsuccessful attempt to demonstrate the virus, heart muscle was injected intracerebrally into a monkey* without producing poliomyelitis. There are no reports in the literature of demonstration of virus in the myocardium.

TREATMENT

In addition to careful general management, therapy consisted of frequent hot moist packs, bed boards, and appropriate daily physical therapy. Tracheotomy was performed six times. In two instances, it was thought to have been life saving, and in one instance it appeared to prevent need of a respirator. As the epidemic progressed, our indications for tracheotomy became more liberal because it was our clinical impression that our first two deaths may have been hastened by aspiration of mucus. While we do not subscribe to performing tracheotomies routinely, we bear in mind that an unnecessary tracheotomy does little harm, whereas a tracheotomy done too late may unnecessarily risk a life. The indications we adopted are those listed by Galloway and Seifert:¹³

1. Progressive anoxia with retained secretion in the upper airway.
2. Unconsciousness or pronounced restlessness in a patient who does not respond to other treatment in a few minutes.
3. Pronounced restlessness or stupor in a patient in a respirator even if the paralysis is apparently of spinal type.
4. Fluid accumulation not otherwise certainly taken care of in a patient who requires a respirator.
5. Bilateral paralysis or spasm of vocal cords.
6. Rapidly progressive bulbar symptoms.
7. Grave signs of vasomotor failure.
8. Untrained or inefficient attendants, inadequate equipment or poor cooperation of the patient, with doubt that the airway will be kept constantly free of secretions.

The respirator was used for five patients with bulbar involvement and for one with spinal. Two of these died and the remainder did well without the machine after from one to nine days.

DIFFERENTIAL DIAGNOSIS

During the height of the epidemic, four patients with what was later demonstrated to be hysteria were admitted as poliomyelitis. One of them was actually placed in a respirator because of severe respiratory distress associated with hyperventilation tetany. Conversely, several patients who subse-

11. Ludden, T. E. and Edwards, J. E.: Carditis in Poliomyelitis; An Anatomic Study of Thirty-five Cases and Review of the Literature. *Am. J. Path.*, 25:357-373, May, 1949.

12. Boucek, R. J., Bailey, A. A., Burchell, H. B. and Edwards, J. E.: Cardiac Clinics; Myocardial Disease in Acute Poliomyelitis. *Proc. Staff Meet., Mayo Clin.*, 24: 495-500, Sept. 14, 1949.

*Attempts to isolate the virus were carried out in the laboratory of Charles A. Evans, Professor of Microbiology.

13. Galloway, T. C. and Seifert, M. H.: Bulbar Poliomyelitis; Favorable Results in Its Treatment as a Problem in Respiratory Obstruction. *J. A. M. A.*, 141:1-8, Sept. 3, 1949.

quently showed definite signs of paralytic poliomyelitis were initially thought to be primarily hysterical and anxiety problems.

The diagnosis of spinal palsy was occasionally in doubt for several days before weakness was clearly manifest. Spasm would sometimes interfere with testing of an area for slight weakness. Also, patients who were subsequently shown not to have poliomyelitis were sometimes found to have enough spasm to warrant use of hot moist packs.

Diagnosis of bulbar palsy was especially obvious since patients almost uniformly presented a clear account of painless difficulty in swallowing, with regurgitation of fluids through the nose, particularly if a large quantity of cold fluid were taken at one time. Asymmetrical elevation of the soft palate was usually observed, although it was sometimes difficult to distinguish this from the asymmetry resulting from scar of old tonsillectomy. Although in a few patients paralysis was limited to swallowing, most of them also developed some weakness of muscles of phonation, frequently associated with visible palsy of a vocal cord and difficulty swallowing saliva which usually was associated with a state of restlessness and anxiety. It was observed that regurgitation of fluids was a peculiarly persistent palsy in some patients, lasting for many months with no sign of improvement. In one patient it was feared that gastrostomy would become necessary in order to maintain nutrition. This patient's pharyngeal palsy was complicated by a paralysis of both masseter muscles, which seriously interfered with chewing. Fortunately, he slowly improved.

Diagnosis of the non-paralytic cases presented many insolvable problems. In addition to the clinical picture, paired sera (acute and convalescent) were studied at the virus laboratory sponsored jointly by the Department of Public Health and Preventive Medicine at the University of Washington School of Medicine and the Washington State Department of Health. The sera were tested for antibodies for lymphocytic choriomeningitis, mumps, lymphogranuloma venereum, Eastern and Western Equine encephalitis, St. Louis encephalomyelitis and Japanese B encephalitis. In no instance was a significant rise in titer noted except two cases, each manifesting an eight-fold increase in mumps complement fixing antibody titer. Absence of benign lymphocytic choriomeningitis is of especial interest since it is not an uncommon clinical diagnosis in this area and had been made on several of our patients prior to entry. To our knowledge, a proved infection due to this virus has not been demonstrated in this state† nor elsewhere on the Pacific Coast.‡

The two patients with mumps are of interest since they did not differ clinically from the remainder of the non-paralytic group and are excluded from the sixty cases of poliomyelitis only by virtue of sero-

logic test. Neither patient developed any parotitis.

While highly speculative and impossible to prove, it is the impression of those who observed the patients clinically that there were twelve patients in the non-paralytic group probably not poliomyelitic. These included two cases with a morbilliform rash compatible with rubella and one who developed herpes zoster over the left thorax on the seventh day of illness. These twelve cases were characterized by higher temperature (rising to 106.7° F. [41.5° C.] in one patient), more severe illness initially manifested by more severe headache, more protracted vomiting and more prostration than the paralytic poliomyelitis patients. Several patients had stupor; one was in coma for twenty-four hours. On the average, spinal fluid cell counts and protein levels were higher. Crises and recoveries were more dramatically sudden. Within twenty-four hours of being critically ill the patient would be eating a regular diet and wishing to be allowed up. No trace of palsy was noted in any of these patients. Possibly these patients suffered from an illness similar to that reported by Jaworski and West¹⁷ and Curnen, Shaw and Melnick¹⁸.

DOES MUSCULAR FATIGUE PREDISPOSE TO PARALYSIS?

While there has been controversy about the importance of preceding fatigue and work in predisposing to paralysis¹⁹ there has been no mention of predominance of paralysis in the dominant limb as an inferential approach to this question. Of the nineteen spinal and eight bulbo-spinal palsy cases, two had bilaterally equal paralysis. Of the remaining twenty-five, twenty-four were right-handed. Seventeen of these twenty-four had paralysis primarily or totally on the right side. Several were workers whose paralysis was most marked in those muscles used most at their jobs. The one left-handed patient was a truck driver whose weakness was limited to the left hand and arm. Thus, 72 per cent of those with asymmetric palsy showed localization in the dominant limb. It is suggested that

†Significant titer of complement fixing antibodies for lymphocytic choriomeningitis has not been demonstrated in tests on seventy-one sera from forty-two patients in the last year.¹⁴

‡For several years careful search has been made for either a rise in complement fixing antibodies for lymphocytic choriomeningitis or presence of the virus (by inoculation of spinal fluid into animals) in numerous cases of aseptic meningitis by the Virus and Rickettsial Disease Laboratory, Department of Public Health, State of California. In no case has benign lymphocytic meningitis been observed.¹⁵

14. Lazarus, A. S.: Personal communication to the author.

15. Lennette, E. H.: Personal communication to the author.

16. Kilham, L., Levens, J. and Enders, J. F.: Nonparalytic Poliomyelitis and Mumps Meningoencephalitis: Differential Diagnosis. *J. A. M. A.*, 140:934-936, July 16, 1949.

17. Jaworski, A. A. and West, E. J.: Aseptic Meningitis of New Virus Origin; Series of Eighteen Cases. *J. A. M. A.*, 141:902-904, Nov. 26, 1949.

18. Curnen, E. C., Shaw, E. W. and Melnick, J. L.: Disease Resembling Nonparalytic Poliomyelitis Associated with a Virus Pathogenic for Infant Mice. *J. A. M. A.*, 141:894-901, Nov. 26, 1949.

19. Russell, W. R.: Poliomyelitis: The Pre-paralytic Stage and the Effect of Physical Activity on the Severity of Paralysis. *Brit. M. J.*, 2:1023-1028, Dec. 27, 1947.

the anterior horn cells supplying muscles of the dominant limb are usually under more work stress than their symmetrical mates and, therefore, more susceptible to virus damage.

PSYCHOSOMATIC ASPECTS OF PARALYTIC POLIOMYELITIS

While it is certainly true that any evidence of delirium in a patient with poliomyelitis must raise the question of anoxia and all its grave implications, there may be less urgent factors. We observed at least three patients in whom delirium was a manifestation of the patient's especial inability to adjust to the illness and its paralytic threat. Examination revealed personality patterns that set the stage for content and character of this reaction. That the delirium content is dependent upon previous personality of the patient and not upon character of the noxious agent has been well demonstrated by Wolff.²⁰ However, the paralytic implications of poliomyelitis hold special terrors for certain personality types. Such individuals might be characterized as actionists. They depend heavily upon taking action in dealing with interpersonal situations. This dominates all aspects of their lives including responses to poliomyelitis—which might deprive them of their only method of adjustment.

Three patients developed this type of response. Two in particular were muscular, athletic young men devoted to hunting, fishing and camping. They volunteered dislike for reading, sitting, or any contemplative enterprise. They were extroverted, restless, and avoided introspection. During delirium, which in all three cases developed several days after admission, they had severe nightmares, worse at night, which revolved about a theme of being caught or tied down or otherwise frustrated when action was demanded. One re-lived a frightening experience of being tied down during an earthquake which caused the walls to collapse in upon him. The other hallucinated that he was caught in a trap while hunting bear in Alaska. They carried need for escape to the extreme that they refused to accept even physical facts of their illness and became disoriented as to time, place and situation. Delirium became fleeting after one week and then suddenly vanished without relation to fever or nutritional status. The third patient, who had had a schizophrenic episode one year prior to her poliomyelitis, became psychotic for four weeks before making an unexpectedly good emotional adjustment to severe quadriplegia.

These changes in behavior are interpreted as being severe anxiety reactions precipitated by the isolation and immobility associated with poliomyelitis in psychologically susceptible individuals. It is suggested that such patients receive special concessions in management since all hope for rest and relaxation

are defeated by delirium, fear and agitation. Use of hot packs and flat bedboards were found to be major offenders. Rest at night may be aided by a night light, avoidance of shadows and use of sedation. One patient obtained remarkable relaxation and sleep from a single 10 mg. injection of morphine. This is, however, a hazardous medication, not to be used without careful consideration.

Mental symptoms during poliomyelitis are usually attributed to encephalitis or cerebral edema. However, as Bodian²¹ states, "Encephalitic symptoms such as restlessness, stupor, disorientation and coma are associated with severe inflammatory reaction in the brain stem and often with small softening in this region. They are not associated with unusual involvement of the cerebral cortex. We have seen no evidence in our material, experimental or human, that edema plays a dominant role . . . (as is) frequently stated." The virus and its destructive effects are virtually limited to the motor strip and the remaining parietal, occipital, frontal and temporal lobes are rarely if ever affected. Even if the delirium is, in part, dependent upon brain stem inflammation, it is felt that a broader psychosomatic point of view may be helpful in management of the patient.

SUMMARY AND CONCLUSIONS

1. The cases of poliomyelitis occurring in adults during one season and observed on a single ward are presented as probably representative of what was occurring simultaneously statewide.
2. The poliomyelitis epidemic year does not coincide with the calendar year but begins in May or June and reaches its peak in the autumn months.
3. Age and sex distributions were not unusual.
4. Incidence of bulbar paralysis is greater among pregnant women than among non-pregnant women.
5. History of a prodrome is much less frequent among adults than among children.
6. Three of thirteen patients had abnormal electrocardiograms. Attempts to isolate poliomyelitis virus from fresh myocardium of a fatal case with clinical evidence of myocarditis were unsuccessful.
7. Tracheotomy is an important adjunct in treatment of bulbar cases but is not advised routinely.
8. No cases of benign lymphocytic choriomeningitis or of other known meningo-encephalitides were found with the exception of two cases of mumps with CNS involvement.
9. Predominance of palsy in dominant limbs is noted and is offered as indirect evidence for the fatigue theory of paralysis involvement.
10. Psychosomatic manifestations were observed.

21. Bodian, D.: Histopathologic Basis of Clinical Findings in Poliomyelitis. *Am. J. Med.*, 6:563-577, May, 1949.

22. Stanfield, C. E.: Personality Repercussions of Anterior Poliomyelitis: A Review of the Literature. *Am. J. M. Sc.*, 213:109-114, Jan., 1947.

23. Ebaugh, F. G. and Hoekstra, C. S.: Psychosomatic Relationships in Acute Anterior Poliomyelitis. *Am. J. M. Sc.*, 213:115-121, Jan., 1947.

20. Wolff, H. G. and Curran, D.: Nature of Delirium and Allied States; Dysergastic Reaction. *Arch. Neurol. & Psychiat.*, 33:1175-1215, June, 1935.

The Effect of Pregnancy on the Mortality Rate of the Tuberculous Woman

N. PATRICK MURPHY, M.D.
SEATTLE, WASHINGTON

THE gravid tuberculous patient confronts her physician with a fundamental question: does tuberculosis justify therapeutic abortion?

A standard obstetrical text,¹ written in 1936, stated, "Early interruption of the pregnancy is the most charitable." This viewpoint was elaborated² in 1940 as follows, "If a tuberculous woman marries she should not have children. If a pregnant patient has florid tuberculosis and it is manifest early, the pregnancy should be interrupted immediately."

By 1943, however, an improved outlook for the pregnant tuberculous woman found expression in the quotation,³ "If the patient with active tuberculosis becomes pregnant, abortion is not indicated. Proper care will enable the patient to go through her pregnancy unharmed."

The data which lend factual support to this more optimistic perspective may be found in a summary of the more recent figures pertinent to this problem (Table 1).

TABLE I

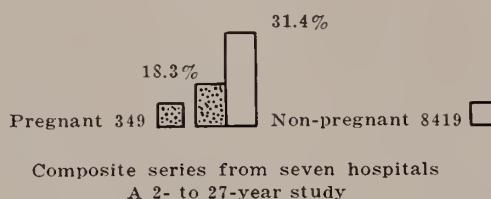
Bib. Ref.	No. Cases	Preg.	Far Adv. or Caseous Pneu. %	Collapse Therapy	No. of Deaths	Mort. Rate %
4	11	Yes	45	Adequate	0	0
5	26	Yes	65	Adequate in 24, inadequate in 2	3	8
6	29	Yes	48	Adequate	1	3.5
7	85	Yes	?	Inadequate	30	36
7	5470	No	?	Inadequate	1805	33
8	82	Yes	72	Adequate	10	12.2
9	86	Yes	50	Not stated	17	20
9	2230	No	44.4	Not stated	725	32.5
10	30	Yes	33	Adequate	3	10
10	719	No	57.4	Adequate	117	16.2
Pregnant		Non-Pregnant				
Total cases		349	Total cases		8419	
Total deaths		64	Total deaths		2647	
Mortality rate		18.3%	Mortality rate		31.4%	

1. DeLee: Principles and Practice of Obstetrics. W. B. Saunders & Co., 1936.
2. DeLee: Principles & Practice of Obstetrics. W. B. Saunders & Co., 1940.
3. DeLee and Greenhill: Principles & Practice of Obstetrics. W. B. Saunders & Co., 1943.
4. Baker, R. H. and Ward, A. D.: Pulmonary Tuberculosis and Pregnancy. New England J. Med., 226:224-227, Feb. 5, 1942.
5. Cutler, J. W.: Harmful Influence of Pregnancy on Advanced Tuberculosis as Modified by Collapse Therapy. Am. J. Obst. and Gynec., 47:1-19, Jan., 1944.
6. Hull, E.: Tuberculosis and Pregnancy. New Orleans M. & S. J., 96:321-324, Jan., 1944.
7. Ornstein, G. G. and Kovnat, M.: Influence of Pregnancy on Pulmonary Tuberculosis. Am. Rev. of Tuberc., 31:224-232, Feb., 1935.
8. Ornstein, G. G. and Epstein, I. G.: Studies on Influence of Pregnancy on Pulmonary Tuberculosis. Quart. Bull. Sea View Hosp., 4:420-429, July, 1939.

In order to arrive at a composite series of sufficient number to justify statistically valid comparisons, a survey of literature from 1921 to 1947 was made. These reports were amplified with data secured from all tuberculosis hospitals of over five hundred-bed capacity.¹¹

Results may be summarized as follows: In three hundred forty-nine pregnant women studied over periods ranging from two to twenty-seven years, with caseous pneumonic or far advanced cases comprising approximately 50 per cent, the mortality rate was 18.3 per cent. In a series of eight thousand four hundred and nineteen non-pregnant patients with similar proportion of advanced lesions treated in the same hospitals under comparable regimens, the mortality rate was 31.4 per cent. (Fig. 1)

Fig. 1
Mortality Rate



Importance of adequate collapse therapy in prognosis for the pregnant tuberculous patient is indicated by the reduction in mortality which has followed its use. Data from two typical institutions are illustrated in figures 2 and 3.

9. Mariette, E. S., Larson, L. M. and Litzenberg, J. C.: Treatment of the Tuberculous Woman During Pregnancy. Am. J. M. Sc., 203:866-874, June, 1942.

10. Mariette, E. S.: Glen Lake Sanatorium, personal communication to the author.

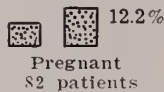
11. Hospitals:
Arkansas Tuberculosis Sanatorium, Logan Co.
Weimar Joint Sanatorium, Pacer Co., Calif.
Norwich State Tuberculosis Sanatorium, Norwich, Conn.
Laurel Heights, State Tuberculosis Sanatorium, Shelton, Conn.
State Tuberculosis Sanatorium, Alto, Ga.
City of Chicago Municipal Tuberculosis Sanatorium.
State Sanatorium for Tuberculosis, Norton, Kansas.
Waverly Hills Sanatorium, Waverly Hills, Ky.
Maryland State Tuberculosis Sanatorium.
Boston Sanatorium, Massachusetts.
Wm. H. Mayburn Sanatorium, Northville, Mich.
Glen Lake Sanatorium, Oak Terrace, Minn.
Robert Koch Hospital, Koch, Mo.
Missouri State Sanatorium, Mount Vernon.
Hudson County Tuberculosis Shop, Jersey City, N. J.
Sea View Hospital, Staten Island, N. Y.
North Carolina Sanatorium for Treatment of Tuberculosis.
Dunham Hospital, Cincinnati, Ohio.

Pennsylvania State Tuberculosis Sanatorium Cresson.
Pennsylvania State Sanatorium, South Mountain.
State Sanatorium, Wallum Lake, Rhode Island.
South Carolina Sanatorium, State Park, S. C.
State Tuberculosis Sanatorium, Sanatorium, Texas.
Pinecrest Sanatorium, Beckley, W. Va.
Hopemont Sanatorium, Hopemont, W. Va.
Muirdale Sanatorium, Milwaukee, Wis.

Figure 2
Mortality rate 1935

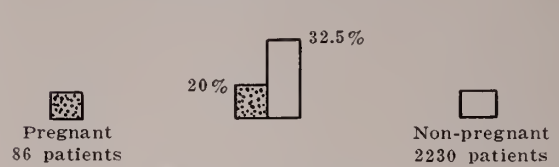


Mortality rate 1939
Adequate collapse

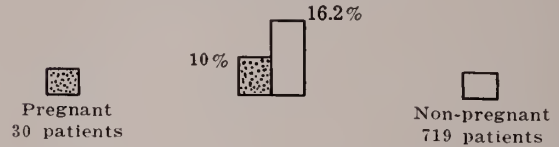


Figures not available for non-pregnant group.

Figure 3
Mortality rate 1921-1940



Mortality rate 1940-1947
Adequate collapse



SUMMARY AND CONCLUSIONS

Mortality rate in a composite series of three hundred and fifty-nine pregnant tuberculous patients was found to be 18.3 per cent as compared to 31.4 per cent in eight thousand four hundred nineteen non-pregnant tuberculous patients comparably treated in the same institutions.

These data indicate that continuation of pregnancy does not affect adversely the mortality rate of the tuberculous patient.

The problem of reactivation of the tuberculous process after pregnancy is more difficult to evaluate because fewer data are available. However, in four small series the rate of exacerbation ranged from nine to twenty-five per cent. The mortality rate in these groups ranged from 0 to 10 per cent. No data were found relating the incidence of exacerbation of arrested tuberculous lesions in non-pregnant patients.

Pleomorphic Adenoma and Adenocarcinoma of Parotid Gland

W. J. SINCLAIR, M.D.*

SPOKANE, WASHINGTON

APPARENT mixture of both epithelial and mesenchymal elements in salivary neoplasms has caused many to consider them subject to special consideration and classification. In this regard Willis¹ has stated, "The term *mixed*, a misnomer when applied to the growths themselves, is an apt enough description of the many conflicting and ill-founded views which have been expressed regarding their histogenesis." He considered them epithelial tumors best termed *pleomorphic adenomas* and *adenocarcinomas*. He introduced this term to indicate that their wide range of structure and behavior permitted them to merge insensibly from simple adenomas to frankly malignant adenocarcinomas.

Non-epithelial elements were explained as effects of altered nutrition, collections of secretion, or products of chemical reaction to salivary ferments. Ewing,² Fry³ and others had previously expressed similar views. Tissue culture experimentation with these neoplasms has tended to support these views.⁴

Pleomorphic nature of these neoplasms has produced a variety of microscopic patterns that lend themselves to a descriptive type of nomenclature. In many instances the supposed specificity of a predominant microscopic pattern has not only been assigned a name but has acquired the stature of a separate neoplasm. Willis,¹ after listing fifteen such descriptive terms, remarked, "this chaos of names is indication enough of the diversity of ill-founded views which have been held regarding the nature of these (mixed) tumors." The so-called cylindroma serves as an example of confusion contributed by descriptive nomenclature.

This term, describing the formation of cylinders or casts, was originally applied to the skin neoplasm *Brooke's Tumor*. Textbooks of pathology and dermatology depict a variety of illustrations under the heading "Cylindroma." McFarland,⁵ Stout⁶ and Willis¹ considered this pattern to be simply one of the many variants of so-called mixed tumors when encountered in a salivary neoplasm. Foot⁷ dismissed the term as one not contributing anything. Quattle-

*Formerly resident in Surgery, Alexander Blain Hospital, Detroit, Michigan

1. Willis, R. A.: Pathology of Tumors. Butterworth & Co., 1948.

2. Ewing, J.: Neoplastic Diseases. W. B. Saunders Co., ed. 4, 1940.

3. Fry, R. M.: The Structure and Origin of the Mixed Tumors of the Salivary Glands. Brit. J. Surg., 15:291-306, Oct., 1927.

4. Zymbal, W. E.: Reference by Willis.

5. McFarland, J.: Ninety Tumors of the Parotid Region, in all of which the postoperative course was traced. Am. J. M. Sc., 172:804-848, Dec., 1926.

6. Stout, A. P.: Human Cancer. Lea & Febiger, 1932.

7. Foot, N. C.: Pathology in Surgery. J. B. Lippincott Co., 1945.

baum, Dockerty and Mayo,⁸ however, considered the pattern sufficiently specific to permit distinction from mixed tumor of the parotid gland and reported twenty-one cases of adenocarcinoma, cylindroma type, in their series of 210 parotid neoplasms. It is interesting to note that had this distinction not been made their cases might have represented a 10 per cent incidence of malignancy for mixed tumor of the parotid gland.

The expected incidence of malignancy, when dealing with mixed salivary neoplasms, is a subject of some conjecture. Keenon⁹ in 1921 reported that 35 per cent of long standing adenomata (mixed tumors) developed malignant change. McFarland⁵ in 1926, using metastasis as a criterion, considered malignant change to be of rare occurrence. In 1932 Stout⁶ expressed a similar view and remarked that microscopic examination during the malignant phase revealed little difference from other carcinomata so that evidence was entirely presumptive as to a mixed tumor origin. Warren¹⁰ in 1938 stated that he had "never seen a mixed tumor metastasize as such."

The statements of Stout⁶ and Warren¹⁰ appear much less remarkable if one considers these neoplasms epithelial and all non-epithelial elements as inert products incapable of growth or dissemination. Willis¹ considered metastases to be rare but stated "the fallacious idea that pleomorphic salivary tumors are benign cannot be too strongly discouraged." Foot⁷ has remarked that Ewing so mistrusted the mixed tumor that he classified them all as malignant.

The case to be presented illustrates many of these introductory remarks. An almost identical case as regards course, behaviour, management, outcome and autopsy findings has been reported by Kornblith¹¹ under the title "Cylindroma" (Mixed Tumor).

CASE REPORT

A white female had noted a pea-sized nodule in the left parotid gland in 1937. Excision on February 28, 1937, was followed by X-ray therapy directed to the left parotid region. Pain associated with recurrence made the patient seek advice in May, 1942, but she refused surgical intervention when advised it would entail sacrifice of the left facial nerve. Excision was carried out on October 17, 1944, because of persistent severe pain and the left facial nerve was sacrificed. Pain was not relieved.

Burning pain, affecting left side of the head, face and ear, associated with recurrence, resulted in a third attempt at surgical extirpation in June, 1948. Neoplastic infiltration of the left Gasserian ganglion was noted at time of operation. X-ray examination re-

vealed probable tumor infiltration of the left mastoid region of the skull and definite metastatic foci in both lung fields.

The patient was next seen April 24, 1949. Examination revealed a small, hard, fixed nodule in the left parotid region and defect in the angle of the left mandible considered to be evidence of recurrent neoplasm. Liver was nodular and enlarged to the pelvic brim. Emaciation was marked. Abdominal pain, anorexia, nausea and vomiting soon developed. There was gradual deterioration. She expired May 4, 1949.

At autopsy, a small nodule of recurrent neoplasm was found in the left parotid region. Angle of the left mandible had been infiltrated and partially destroyed by recurrent tumor. Multiple neoplastic nodules were present in both lungs. The liver weighed 3500 Gm. and had been almost completely replaced by neoplasm. Sections of the neoplasm taken from the left parotid region, angle of the left mandible, lungs and liver revealed similar microscopic features. Pleomorphic nature of the lesion was striking. Patterns resembling cylindroma, basal cell carcinoma, adenocarcinoma and medullary carcinoma were readily apparent. Blood vessel and bronchiole invasion were noted in the lung sections.

COMMENT

Highly respected pathologic opinions were rendered concerning material examined during the twelve-year course of this lesion. Three different pathologists studied the material during this period. Descriptive terms employed were medullary carcinoma, adenocarcinoma, eosinophilic granular-celled adenoma, oncocytoma, and pleomorphic adenoma and adenocarcinoma of the parotid gland. Patterns resembling basal cell epithelioma and cylindroma were present in metastatic lesions and these terms might also have been added to the list. Of more importance, however, were the divergent opinions expressed regarding the malignant potential of the lesion when reviewed in 1949 as contrasted to that given for the original twelve years previously. The well-known difficulty of histologic interpretation was thus well illustrated.

It should be recalled that the neoplasm was small at the time of the original operation and total parotidectomy or lobectomy would have offered an excellent chance of cure. Five years had elapsed and destructive invasion of nerves in the parotid region had occurred when radical surgery was proposed and refused. Surgical intervention, later submitted to because of the progressive severity of pain, was too late to control either lesion or pain.

McFarland⁵ has reported 63 per cent incidence of recurrence, with cases followed seven years, when radical surgical excision was not employed. Because larger lesions have been found associated with reduced rate of recurrence following excision, it has been implied by some (McFarland⁵, Boyd¹², Martin¹³) that excision be delayed to permit enlargement. This unique proposal for management of a

8. Quattlebaum, M. B., Dockerty, F. W. and Mayo, C. W.: Adenocarcinoma, Cylindroma Type, of the Parotid Gland; Clinical and Pathological Study of 21 Cases. *Surg., Gynec. & Obst.*, 82:342-347, March, 1946.

9. Keenon, R.: Tumors of the Salivary Glands With Their After History. *Brit. J. Surg.*, 9:76-86, July, 1921.

10. Swinton, N. W. and Warren, S.: Salivary Gland Tumors. *Surg., Gynec. & Obst.*, 67:424-435, Oct., 1938.

11. Kornblith, B. A.: Cylindroma (Mixed Tumors) of the Parotid Region With Visceral Metastases. *J. Mt. Sinai Hospital*, 7:38-43, May-June, 1939.

12. Boyd, P. L.: Mixed Tumors of the Parotid Type, With Report of Three Cases. *Am. J. Surg.*, 39:641-645, March, 1938.

13. Martin, T. M.: Treatment of the Tumor of the Parotid Gland; Survey of Results Obtained at Barnard Free Skin and Cancer Hospital. *Arch. Surg.*, 36:136-143, Jan., 1938.

neoplasm was all the more surprising since it had been suggested for a tumor that did not conform to usual pathologic considerations that permit selective management. The gravity of delayed or inadequate therapy was demonstrated by Quattlebaum, Dockerty and Mayo⁸ when they found that 25 per cent of their malignant cases had partial or complete facial paralysis when first examined and 50 per cent had developed infiltration of the facial nerve before the first operation.

Because of their location, parotid neoplasms should receive prompt attention. Viewed with a complacency uncommon to neoplasms of other organs, this advantage has frequently been lost. Fear of nerve injury or salivary fistula formation or both has unfavorably influenced management of large lesions and has encouraged restrained surgical attacks on small lesions. Confusion concerning malignant potential of the neoplasm itself has encouraged complacency and delayed definitive surgery. Bailey¹⁴ has stated that "in the whole realm of clinical surgery there is not a condition that approaches mixed parotid tumors for misconceptions. A supremely curable lesion is allowed to go for years and pass to incurability because of misconceptions of behavior and treatment."

McWhorter¹⁵ in 1917 contributed the fundamental anatomic considerations necessary for successful parotidectomy without nerve injury. Adson and Ott¹⁶ in 1928 and Bailey¹⁴ in 1941 described surgical techniques based on anatomic studies. Anson, *et al.*¹⁷ in 1945 and Hurford¹⁸ in 1946 also contrib-

uted to knowledge of the surgical anatomy of the parotid region. It is clear from these reports that the facial nerve, in most instances, occupies a plane between the superficial and deep lobes of the parotid gland and, as a result, injury to the nerve can be avoided. That it is not injured when this knowledge is applied has been shown by Bailey,¹⁴ Trueblood,¹⁹ Janes²⁰ and others. Nerve injury is more likely to result from unchecked growth of the tumor than from operative injury.

Success of these surgeons with total parotidectomy and lobectomy has done much to allay fears of nerve injury and fistula formation and has accelerated the present trend toward radical parotid surgery. Nevertheless, even current literature refers to cases treated by the inadequate procedure of enucleation. Since it has been demonstrated that this non-essential organ can be totally removed without undue risk to the patient it is felt that the early institution of total parotidectomy or lobectomy for all parotid neoplasms would circumvent many of the problems associated with their pathological assessment and would minimize the risk of recurrence and malignant change.

SUMMARY

Mixture of epithelial and mesenchymal elements in tumors of the parotid has caused confusion. Non-epithelial material is inert, not capable of reproduction and is not present in metastases. The term *mixed tumor* should be replaced by *pleomorphic adenoma and adenocarcinoma*. Enucleation is inadequate. Such tumors should always be treated by total extirpation of the parotid or by lobectomy.

14. Bailey, H.: Treatment of Tumors of the Parotid Gland, With Special Reference to Total Parotidectomy. *Brit. J. Surg.*, 28:337-346, Jan., 1941.

15. McWhorter, G. L.: The Relation of the Deep and Superficial Lobes of the Parotid Gland to the Ducts and to the Facial Nerve. *Anat. Rec.*, 12:149, 1917.

16. Adson, A. W. and Ott, W. D.: Preservation of the Facial Nerve in Radical Treatment of Parotid Tumors. *Arch. Surg.*, 6:739-746, May, 1923.

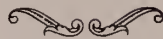
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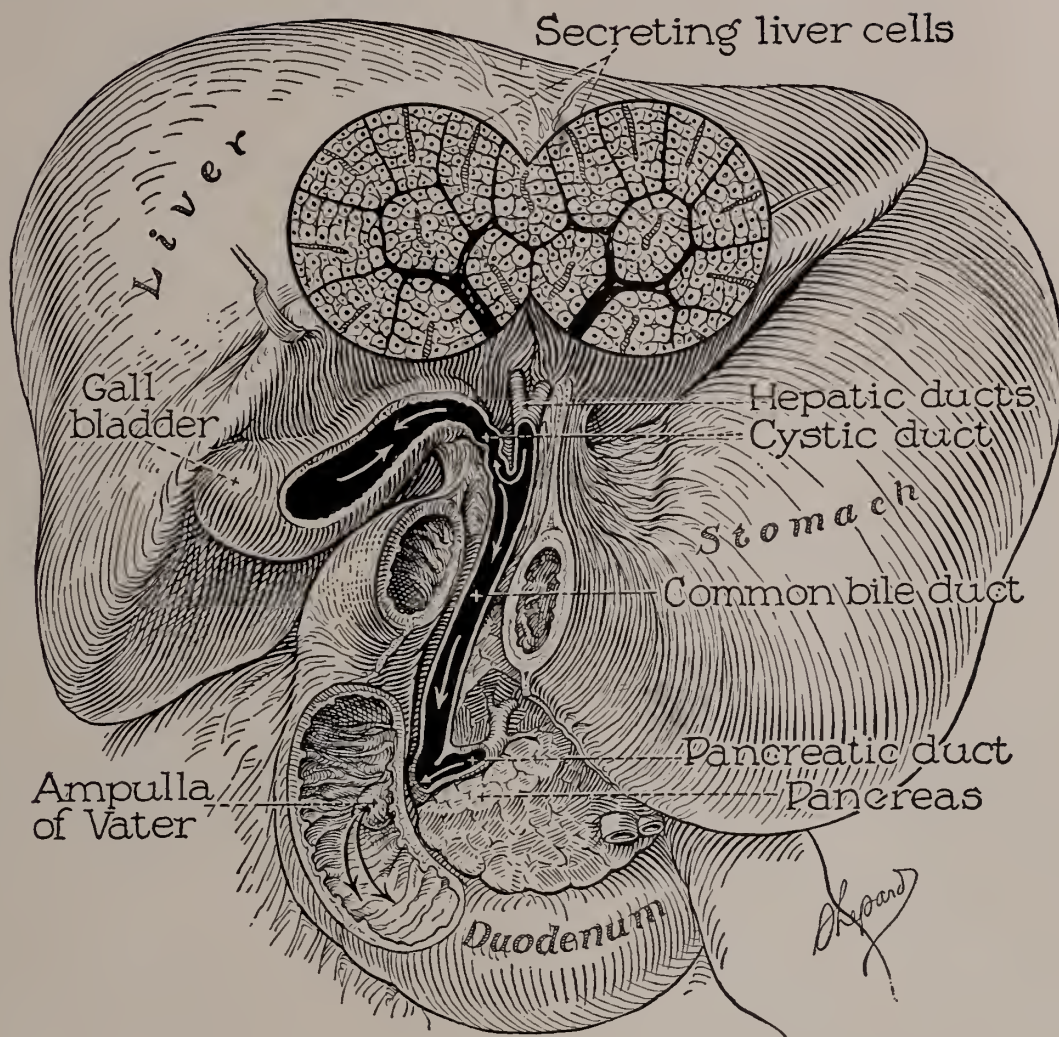
18. Hurford, F. R.: The Surgical Anatomy of the Parotid Gland. *Brit. J. Surg.*, 34:186-187, Oct., 1946.

19. Trueblood, D. V.: Clinical Observations and Surgical Experiences With Parotid Tumors. *West. J. Surg.*, 52:109-118, March, 1944.

20. Janes, R. M.: The Treatment of Tumors of the Salivary Gland by Radical Excision. *Canad. M. A. J.*, 43:554-559, Dec., 1940.

21. Montanus, W. P.: Mixed Tumors of Parotid Gland With Metastases. *Surgery*, 4:423-429, Sept., 1938.





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Western Conference of Prepaid Medical Care Plans Convenes in Seattle November 9-10

By **WENDELL H. BROYLES**, *Director, Public Relations*
King County Medical Service Bureau

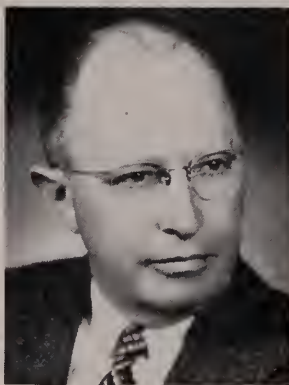
Representatives of the doctor-sponsored prepaid medical care plans in six western states and several Canadian provinces will come to Seattle November 9 and 10, for the annual fall meeting of Western Conference of Prepaid Medical Care Plans. More than 100 physicians and bureau managers are expected to register at the Olympic Hotel for the two-day session.

Represented will be all of the 22 doctor-sponsored medical bureaus in Washington; the Oregon Physicians' Service; the Klamath Medical Service Bureau of Klamath Falls, Oregon; the California Physicians' Service; Utah State Medical Service Bureau; Montana Physicians' Service; North Idaho District Medical Service Bureau; Medical Services Association of Vancouver, B. C.; Group Medical Services of Regina, Saskatchewan; and Medical Services, Inc., of Edmonton, Alberta. Largest of the plans is California Physi-

cians' Service through which more than 1,000,000 persons have coverage. The 22 plans in Washington extend coverage to about 350,000 persons.

Mr. George W. Cooley of the Council on Medical Service of the American Medical Association, with headquarters in Chicago, will come to Seattle for the meeting.

GUEST SPEAKERS



MR. HARRY HOUSE
Tacoma, Wash.



MR. ED WESTON
Seattle

GUEST SPEAKERS



A. O. PITMAN
Hillsboro, Oregon



WENDELL C. KNUDSON
Seattle

One of the outstanding figures in the medical field in Oregon is Dr. A. O. Pitman of Hillsboro. A strong supporter of voluntary prepaid medical care programs, Dr. Pitman is speaker of the House of Delegates of the Oregon State Medical Association and is a trustee of the Oregon Physicians Service. He will tell representatives to the Western Conference meeting of "Prepaid Plans in Oregon."

A strong advocate of the medical profession's participation in voluntary prepaid medicine as "the best answer we now have to the desire and need for this type of care" is Wendell C. Knudson of Seattle. He has been a member of the Board of Trustees of the King County Medical Service Corporation for the past five years and on October 24 concluded a year of service as its president. He will talk to representatives at the Western Conference meeting on "Why Are Doctor-Sponsored Prepaid Plans Good for the Physicians?"

Dean of medical bureau managers in the West is Mr. Harry House, for 21 years manager of the Pierce County Industrial Medical Bureau of Tacoma. As manager, for this period of time, of the first doctor-sponsored prepaid medical care bureau in the nation, House has been a leader in the field in Washington and is one of the country's real experts. He will be one of the featured speakers at the Western Conference meeting, telling the delegates his slant on "What's Ahead in Prepaid Medicine."

One of the knottiest problems facing representatives to the meeting of the Western Conference of Prepaid Medical Care Plans in Seattle November 9 and 10—labor's attitude toward and desire for prepaid medical, surgical and hospital care—will be discussed at length by one of the outstanding experts on the subject, Mr. Ed Weston, president of the Washington State Federation of Labor. Long an outstanding leader in the labor field in the Pacific Northwest, Mr. Weston will tell the physicians and prepaid plan managers, "What the Unions Expect of Prepaid Medical Care Plans."

Chairman of the Conference is Ray T. Woolsey, of the Utah State Medical Service Bureau of Salt Lake City, and the secretary is Gerald Watson, of the Medical Services Association of Vancouver, B. C.

Topics scheduled for discussion at the meeting include the strong trend toward coverage through union-negotiated, employer-paid welfare plans; the

demand for one-package plans, including life, time loss and accident insurance coupled with medical and hospital coverage; and the problem of better coverage for subscribers moving from one area to another in the western area.

The speakers at the convention will include Mr. Willard Marshall, former General Manager of the Oregon Physicians' Service; Mr. Harry House, manager of the Pierce County Industrial Medical Bureau of Tacoma; Mr. Sam English, Executive Director of the Montana Physicians' Service; Wendell Knudson, who retired in October as President of the King County Medical Service Corporation; R. A. Benson,

President of the Washington State Medical Association; Mr. Ed Weston, President of the Washington State Federation of Labor; Alfred M. Popma, President of the Idaho State Medical Association; A. O. Pitman, of Hillsboro, Oregon; James McCabe of Helena, Montana; E. C. McCoy, outstanding Vancouver, B. C. physician; and Mr. George La Fray, General Manager of the King County Medical Service Corporation of Seattle.

A luncheon honoring representatives to the Convention will be held Friday, noon, November 9. That night a reception and dinner will be held for all delegates and their families.

Care Plans Originated in Pierce County, Washington, in 1917

It is fitting that the west should lead the country in scope and caliber of care offered through prepaid medical care plans, for it was here that the now prevalent doctor-sponsored service type plans originated.

It is generally conceded that honors for being the first such plan in the country go to the Pierce County Industrial Medical Bureau of Tacoma, which was formed in 1917. The Tacoma plan pioneered the field virtually alone for the first fifteen years until many other such plans were formed in the early 1930's.

In 1933 the King County Medical Service Corporation and the Yakima Medical Service Association entered the field to meet the need in their areas. King County Medical, operating only in its home county, now has 148,000 persons covered, which is approximately one out of every five persons in the county or one out of every three employed persons. These plans have contributed much, along with Tacoma, to help pioneer the field.

The California Physicians' Service, organized in 1939, and a comparative newcomer in the field, now is largest of the plans in the west with more than one million subscribers and over 10,000 doctors participating.

Today the doctor-sponsored prepaid care picture in the West, as carried on through doctor-sponsored plans, looks like this:

California:	The field dominated by CPS.
Oregon:	Oregon Physicians Service extends care to virtually all of state though several areas have their own plans.
Washington:	There are 22 independent medical bureaus extending coverage to about 350,000 persons.
Idaho:	The state serviced by North Idaho District Medical Service Bureau of Lewiston and the Southern Idaho Medical Service Bureau of Pocatello.
Montana:	Montana Physicians Service covers the entire state.
Utah:	Utah State Medical Service Bureau, headquartered in Salt Lake City, covers the entire state.
British Columbia:	The Medical Services Association of Vancouver covers that area.

Guest Speakers



MR. JOHN STEEN
Seattle

A. G. YOUNG
Wenatchee

Much credit for the efficient manner in which the coming meeting of the Western Conference of Prepaid Medical Plans has been arranged belongs to John Steen, manager of the Washington Physicians Service, who is program chairman for the event. Steen was manager of the Thurston County Medical Service Bureau in Olympia from 1933 to 1947 and during part of this period devoted a share of his time to directing activities of the Washington State Medical Bureau, which was then located in Olympia. When the bureau was moved to Seattle in 1947 Steen moved in as full-time manager and, with its name now changed to Washington Physicians Service, he continues to direct its activities.

An exceptionally active man in community and state affairs is Dr. A. G. Young of Wenatchee, now starting his second term as president of the Washington Physicians Service. With WPS in the role of host at the Western Conference meeting, Dr. Young will open the convention by welcoming the more than 100 physicians and bureau managers to Seattle.

In addition to his duties with WPS, Dr. Young is medical advisor for the Chelan County Medical Bureau, a delegate from the State of Washington to the American Medical Association.

Western Conference of Prepaid Medical Service Plans

Seattle, Washington — Olympic Hotel

Junior Ballroom

Friday, November 9, and Saturday, November 10, 1951

Agenda

RAY T. WOOLSEY, M.D., Salt Lake City, Utah, *Chairman*
G. L. WATSON, M.D., Vancouver, B. C., *Secretary*

Friday Morning, November 9

- 9:00 Registration
- 9:30 Call to Order, Roll Call, Adoption of Minutes of Preceding Meeting, Address of Welcome by A. G. Young, M.D., Wenatchee, Wash., President, Washington Physicians' Service.
- 10:00 "WHY ARE DOCTOR - SPONSORED PLANS GOOD FOR THE PHYSICIAN?"
Wendell C. Knudson, M.D., Seattle, Wash., Immediate Past-President, King County Medical Service Corp.
General Discussion (all plans).
- 10:30 "PREPAID PLANS IN OREGON"
A. O. Pitman, M.D., Hillsboro, Oregon, Speaker of the House of Delegates, Oregon State Medical Society and Trustee, Oregon Physicians Service.
General Discussion (all plans).
- 10:50 "ADMINISTRATION OF CLAIMS"
James McCabe, M.D., Helena, Montana, Secretary, Montana Physicians' Service.
General Discussion (all plans).
- 11:10 "TRANS-CANADA MEDICAL SERVICES"
E. C. McCoy, M.D., Vancouver, B. C., Treasurer, Trans-Canada Medical Services Commission.
General Discussion (all plans).
- 11:30 "PREPAID PLANS IN IDAHO"
Alfred M. Popma, M.D., Boise, Idaho, President, Idaho State Medical Association.
General Discussion (all plans).
- 12:00 noon LUNCHEON, PARLOR E and F
"WHAT THE UNIONS EXPECT OF THE PREPAID PLAN"
Mr. Ed M. Weston, Seattle, Wash., President, Washington State Federation of Labor.
- 12:00 noon THE LADIES WILL BE ENTERTAINED AT A LUNCHEON BY THE WASHINGTON STATE MEDICAL ASSOCIATION

Friday Afternoon, November 9

- 2:00 "TWENTY-ONE YEARS EXPERIENCE IN PREPAID PLANS"
Mr. Willard Marshall, Salem, Oregon, former General Manager, Oregon Physicians' Service.
General Discussion (all plans).
- 2:30 "WHERE DO WE GO FROM HERE?"
Mr. Harry House, Tacoma, Wash., Twenty-one years General Manager, Pierce County Industrial Medical Bureau.
- 3:00 "WHAT I HEAR"
Mr. Howard L. Barnes, Seattle, Wash., Public Relations Director, Washington State Medical Association.
General Discussion (all plans).
- 3:15 "THE ONE-PACKAGE DEAL"
Mr. Joseph Harvey, Portland, Oregon, General Manager Oregon Physicians' Service and Mr. W. W. Campbell, San Francisco, California, Administrative Assistant California Physicians' Service.
General Discussion (all plans).
- 3:45 "TRENDS"
Mr. George La Fray, Seattle, Wash., General Manager, King County Medical Service Corp.
General Discussion (all plans).

Guest Speakers



ALFRED POPMA
Boise, Idaho



MR. GEORGE LA FRAY
Seattle

A featured speaker at the meeting of the Western Conference of Prepaid Medical Plans in Seattle November 9 and 10 will be Alfred Popma of Boise, Idaho, pictured above, president of the Idaho State Medical Association.

One of the outstanding roentgenologists in the Pacific Northwest, Dr. Popma is exceptionally active in affairs of the various physicians' organizations in the area. Dr. Popma graduated from the University of Iowa College of Medicine in 1932 and has practiced in Idaho most of the time since then. For some time he was secretary of the Idaho State Medical Association and now is president of that organization.

An analysis of the trends now apparent in the service-type prepaid medical care programs, both from the standpoints of costs and service, will be presented to the Western Conference meeting by George LaFray, General Manager of the King County Medical Service Corporation of Seattle.

One of the Pacific Northwest's outstanding insurance experts, LaFray was with the Northern Life Insurance Company for more than 25 years and was a vice-president at the time he went into the service in 1942 as a Lieutenant Colonel. After leaving the services as a colonel he became affiliated with the Veterans Administration as Director of the Northwest Branch.

In 1948 he was named general manager of King County Medical Service Bureau and has been with the organization since that time. Outstanding in community affairs, he served for some time on the board of Seattle General Hospital, on the board of the YMCA, was president of the Municipal League and was on the board of the Community Chest.

- 4:15 "REPORT OF THE COMMITTEE ON INTER-PLAN TRANSFERS"
Mr. Sam English, Helena, Montana, Executive Director, Montana Physicians' Service. General Discussion (all plans).
- 6:00 COCKTAIL HOUR—JUNIOR BALLROOM.
Washington Physicians' Service, host.
- 7:00 FAMILY DINNER
"MEDICAL PROFESSION ENDORSEMENT OF THE PREPAID PLAN"
R. A. Benson, M.D., President, Washington State Medical Association.

Saturday Morning, November 10

- 10:00 COMMITTEE REPORTS
- 10:30 REVIEW OF PROBLEMS PRESENTED AT FRIDAY'S SESSIONS
M. Shelby Jared, M.D., Medical Director, King County Medical Service Corp.
General Discussion (all plans).
TIME AND PLACE OF NEXT MEETING
ELECTION OF OFFICERS
ADJOURNMENT

Guest Speakers

E. C. MCCOY
Vancouver, B. C.



R. A. BENSON
President, W.S.M.A.

E. C. McCoy, one of the outstanding and most brilliant young physicians in Canada, will be featured speaker at meeting of the Western Conference of Prepaid Medical Care Plans.

A graduate of McGill University in 1939 and now a general practitioner in Vancouver, B. C., Dr. McCoy is vice-president of the Vancouver Medical Association; a national executive of the General Practitioners Section of the Canadian Medical Association and treasurer of the Trans-Canada Medical Service Commission. In addition to these activities he is vice-chairman of the Health Bureau of the Vancouver Board of Trade.

He will tell representatives to the meeting about "Trans-Canadian Medical Services."

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Fifth District (Coos, Curry, Douglas, Jackson and Josephine Counties): Dwight H. Findley, Medford (1954)	Councilor-at-Large.....Marion Reed East, Portland (re-elected; 1954)

Opinions, views or comments presented in articles appearing in this section are those of the individual authors and are not necessarily those of Oregon State Medical Society.

Doctor Fee Confusion in Indemnity and "Search" Insurance

Periodically doctors are bewildered by the confusion which seems to attend the operations of medical indemnity insurance, and also by requests received from insurance companies, usually life, for search of doctors' records. In the opinion of this writer much of the confusion results from both doctor and lay misunderstanding, or loose use, of certain terms and procedures, particularly the identification of a scale of reimbursements for medical services as a "fee schedule" binding upon doctors.

The theory of medical indemnity insurance is that *patients are reimbursed* for medical charges up to an amount agreed upon between the insurance company and the patient as evidenced in the insurance contract. The doctor does not enter into an agreement to accept such an amount, is not even consulted in fixing such amount, and in fact is entirely outside the contract between insurance company and patient. The doctor's fee is a matter between his patient and himself, and may be more or less than the amount as to which the insurance company has agreed to reimburse the patient.

Regardless of the above, sometimes the literature of an insurance company or other indemnifying agency is drafted so that the patient or the doctor may conceive that the amount fixed by the insurance agreement is the amount the patient should pay the doctor.

Literature of the Oregon Student Activities Association, which the writer has seen recently, may be interpreted as attempting to fix doctors' fees. This interpretation is probably not intended by the Association. However, the literature states: "*In the payment of doctors and hospitals, the schedule of rates shall be on the basis of family rates, but shall not exceed those of the State Industrial Accident Commission as of July 1, 1949 . . .*" (Emphasis ours.)

The writer wishes to emphasize as his opinion that the doctor is not bound to accept the fee schedule of the Association, and that the doctor is justified in sending the patient a statement for a reasonable fee. The doctor can inform the patient of his fee, and credit the patient with any amount received by the doctor from the Association, since the latter in its literature has stated its intent to make payment directly to doctors for services rendered its policyholders.

Aside from the above, a small number of insurance companies appear to have adopted the practice of sending to doctors a "search and report" request to aid insurers in evaluating the risk status of an applicant, and accompanying the request with a \$2.00 check made payable to the doctor.

The doctor need not make the requested report for the \$2.00 fee, if he believes the work involved requires

a larger fee. He can return the check with a note stating that his fee is a larger, or a smaller, amount; the practice in some communities of the state seems to be that such a report requires services reasonably worth at least \$3.00.

GORDON LEITCH

Committee of Western Conference of Medical Service Plans Recommends Transfer Plan

The Conference of Western Medical Service Plans, through activities and studies of its inter-plan transfer committee, has moved a step closer toward eliminating one of the "bugs" in service plans which arouse considerable subscriber annoyance, the loss or diminution of benefits when removing from the jurisdiction of one plan to that of another.

Heretofore, when a service plan subscriber moved to a different area within a state, or to another state, it frequently happened that such subscriber was subjected to fresh waiting periods and other restrictions before the new coverage became operative. It also happened that coverage offered varies in different areas, the differences involved frequently resulting in dissatisfaction. An informal arrangement was honored among some plans with similar structures in the past, but until recent studies of this committee no attempt had been made to establish basic principles of transfer which would be most acceptable to subscribers and satisfactory to the plans involved.

At the national level this problem was approached by the Blue Shield Association through attempts to offer uniform benefits, and formation of the Blue Shield Insurance Company resulted. The western medical service plans, by contrast, felt the problem might be solved in a less regimented manner which would reconcile the legitimate desires of subscribers with the local necessities of the service plans.

Under the proposals, which will not be operative conference-wide until approved by each of the adhering plans, the plan to which a subscriber transfers will give credit to a transferring subscriber for the length of time such subscriber has held continuous prior membership in another participating plan, or plans, toward fulfilling waiting period requirements established by the plan to which transfer is made. The various technical procedures to accomplish this purpose with the minimum of confusion to subscriber and the plans concerned were discussed at some length and will be effective when the transfer plan is approved by the plans participating.

Interesting sidelight of the sub-conference was the request received from a number of Canadian plans offering service benefits that they be invited to participate in the arrangements and future meetings of the Western Conference of Medical Service Plans. Such requests were made on behalf of Physicians' Service, Inc., Toronto, Ontario; Manitoba Medical Service, Winnipeg, Manitoba; Medical Service Saskatoon, Inc., Saskatoon, Saskatchewan; Group Medical Services, Regina, Sask.; Maritime Medical Care, Halifax, Nova Scotia; Medical Service (Alberta), Inc., Edmonton, Alberta, and Medical Service Association, Vancouver, B. C.

The 1951 annual meeting of the Western Conference of Medical Service Plans is scheduled to be held in Seattle November 9 and 10.

The special Inter-plan Transfer Committee, which met in Portland, was composed of Samuel English, Montana Physicians' Service, chairman; Mr. John Steen, Washington State Medical Bureau; Mr. George LaFray, King County Medical Service Corp.; Allen H. Tibbals, Utah Medical Service Association; William Campbell, California Physicians' Service; Thomas Dean, North Idaho Medical Service Bureau, and W. C. Marshall, Oregon Physicians' Service. Attending the meeting on behalf of the Canadian plans was A. L. McLellan, Medical Services Association, Vancouver, B. C.

Pete the Pest Says

Tax Note: Colleagues of upstate doc with thrifty reputation have finally solved riddle of where chap gets odds and ends of bits of paper on which for months they've been getting telephone numbers, patients' names, addresses, "gone golfing until 6:00" and other memos scribbled on surface.

Methodically clips backs from envelopes, folders and the like reaching him daily in second to fourth class mail from drug houses, stock brokers, promoters and what have you including Congress and A. M. A. Stashes them in piles in top desk drawer where they're handy, which is why associates didn't make discovery earlier.

Now his pals are trying to figure out way to break a fact of life to gent without getting him mad enough to have a heart attack, and which one gets job of telling Old Thrifty he has cheated himself. If he'd buy memo pads for office they could be tax deducted as business expense. So all the time he figgered he was getting free memo paper he was really buyin' the stuff through unrealized taxes!

(Tell him about Capitol Clinic, and Bulletins, from A. M. A. Washington office. Better quality paper and one way to recover part of his A. M. A. dues, if he doesn't mind writin' on the back!—Pete.)

Leave Us Weep: Complaints have been reaching officials about irregular advertisement which appeared in Tualatin Valley news sheet giving location, telephones and hours of medical group near Portland.

Competitors don't like "9 to 9" and "evening surgery" statements. State medical board doesn't like clear-cut violation use of "clinic" without legal specification "physicians and surgeons" (Howya gointa crack down on quacks 'n' cultists if yer own hands is dirty?). And perpetratin' docs are reported unhappy because printer set ad between two great big wide black bands, undertaker style!

Doctors Cheaper: Costs more to eat than have a doctor. Medical costs scaled against prewar figgers made on June reckoning show increase of 54.7 per cent for docs and drugs together. For same period food costs went up 126.8 per cent. But, look, hospital rates went up 161.4 per cent!

Free Silver: See where Judge Alexander Holtzoff, bench warmin' in fracas between Indiana and Oscar Ewing's F. S. A., rejected motion for court order telling Oscar to resume federal payments for Indiana welfare which he cut off when Indianans decided to publish names to curb abuses. Nix, sez judge, the federal govt. (that's Oscar) *may attach conditions to its grants*. Latest wrinkle in applying old new deal principle govt. may control what it subsidizes. You still want federal silver for medical schools?

Who Said Sheep? All five Portland hospitals which voted "No" in poll of American Hospital Association on intern "matching" plan, as deadline for acceptance specified by "NIIC" committee approached, changed attitudes, signed up with matching program. Which caused one hospital staffer to wonder out loud why they didn't vote "ja" in the first place instead of tryin' to confuse the Amer. Hosp. Association.

Helping Nurse Shortage: Tale of mid-August incident in Portland hospital is making rounds of nurse grapevine, doing something to certain doc's standing with nursing gals, if that's important.

Graduate nurse, a little plump or husky (you want your nurses shouldn't have muscles?) but long way from fat in the head, was added to staff, assigned two days of observation in surgery before taking regular job as instrument nurse. Gal is capable and experienced, but surgical supervisor thought breaking-in would be easier if she could see actual operating room technics and personal oddities displayed by various surgical gents.

Gal first crack out drew specialist hot shot, who, seeing her standing around jes' watchin', loudly demanded why any nurse in his surgery has nothin' to do, yelled put her to work or get her out, cut short attempted explanation with barrage of comments of personal nature directed at gal's size and what have you, culminating in opinion he'd lay days in bed before lettin' himself get that fat.

New gal took layin' out tirade without comment, was finally rescued red-faced and on verge of tears by some other surgical floor girls who had trouble keeping their tops on. "Wotinells the matter with the guy?" sez one irate circulator, "you gotta be a model before you can stick yer snoot in his blankety blank surgery? And they want to know why nurses leave hospitals!"

Nurse in question wanted very much to be nurse. Had to leave training account short finances but took business course to be stenographer so she could earn more dough to save extra to complete her nursing. Worked in shipyards while studying stenno, finally returned to finish nurse training once she had enough nest egg to see her through. Now wonders why she has to be insulted in order to work as a nurse, and if it's worth it. (Contributed by H. E.)

(Note to nursing offices: Your nurses which is fashion models come equipped with recognizing instructions so a gent can be sure when their qualifications is hid with surgical mask 'n' outfit?)

New Treatment: Hey, doc, you been layin' in bed lately for that bay window?

Marshall Retires From O. P. S.

Willard C. Marshall, general manager of Oregon Physicians' Service, after having been associated with doctor-sponsored medical and hospital plans in Oregon since their inception in 1930, has announced that he is retiring from that position effective October 15.

At the same time the board of directors of Oregon Physicians' Service has announced the promotion of Joseph E. Harvey, Jr., to the post of general manager. Joe Harvey has served as assistant general manager for the past four years and has been affiliated with O. P. S. for nine years.

Thorne H. Hammond, who has served as executive assistant in the Portland office for the past five years, has been promoted to the post of assistant general manager. Both Harvey and Hammond are Portland men and are well known in business and professional prepaid medical circles.

Willard Marshall has been associated with O. P. S. as general manager since its beginning in 1941 and helped to organize the Physicians and Surgeons Hospital Association of Salem in 1930 and served as its manager for eleven years. The Physicians and Surgeons Hospital Association was amalgamated into Oregon Physicians' Service in 1941. Incidentally, Willard has a mark at which some of the salesmen might shoot. He admits to installing about 40 contracts in the first month of operation of P. & S. H. A. and since he was



MR. JOSEPH E. HARVEY, JR.
MR. THORNE H. HAMMOND
MR. WILLARD C. MARSHALL

a one-man force this meant drawing up the contracts, selling and installing, packaging and delivering all first aid supplies as well as administering the contracts. He says he was a busy man.

Although management of his personal business interests in Salem will occupy most of his time, he will continue to make his twenty-one years' experience in the prepaid medical field available as a consultant.

What They Said About Foley, Who Is Going to "Try for Fifty"



MR. CLYDE FOLEY, Honored Guest, at head table just before he was presented with the keys to a new Pontiac sedan.

One hundred and sixty-eight organizations were represented at the 77th annual banquet of the Oregon State Medical Society, honoring Mr. Clyde Foley, at the Multnomah Hotel, Friday evening, October 12.

Delegates and their wives and participating guests jammed the Grand ballroom, overflowed into the Junior ballroom and filled the Emerald and Colonial rooms where hurried accommodations had to be installed.

It was the Society's "biggest ever" banquet, following in the wake of the largest and best convention staged in years. Some said there were 550 people seated at the tables.

NORTHWEST MEDICINE cannot carry all the nice things said about Mr. Foley in recognition of his 25 years' service as executive-secretary of the Society, starting in 1926. But here are excerpts:

JOHN W. KLINE, M.D., president of AMA: I am highly honored with this opportunity to participate in a tribute to Clyde Foley. In discussing with him his many problems as secretary, I suggested that it was regrettable that a man of his talents did not have more attractive employment. Mr. Foley said there was no more attractive employment.

BLAIR HOLCOMB, president, OSMS: Calvin Coolidge was president when Clyde Foley came to us as secretary. Clyde is in many ways a prototype of "Silent Cal" . . . a grand guy who has done a wonderful job for us.

JOHN H. FITZGIBBON, toastmaster: Clyde is a great American—the kind who makes this country what it is. I say this with reverence.

THE HONORABLE DOUGLAS MCKAY, Governor of Oregon: A great fellow working with a bunch of prima donnas, witness all the calls (during the dinner) for doctors and none for the governor. I hope you all appreciate what he has done for you.

THE HONORABLE DOROTHY MCCULLOUGH LEE, mayor of Portland: As the daughter of a doctor I have a high conception of your true mission as guardians of our physical welfare. Health is our most precious asset and I pay tribute to the man who has served the medical profession for 25 years and worked with me as a liaison officer for all the groups in the fields of healing.

HARRY M. KENIN, classmate and former instructor, Reed College and U. of W.: Thirty years ago Foley weighed 140 pounds. He did four years' work in three at Reed College and worked eight hours a day for Portland Gas Co. to pay his way . . . a very fine second baseman . . . outstanding achievement has been his work for the basic science law . . . may God grant you an increased salary.

WALTER W. R. MAY, Oregon Health Association: When I first knew him he was a thin, eager, ambitious, hungry Brutus of a man. Now he is a Cæsar, calling the plays of a great profession. "It is a great warrant of ability to have served one thing well for a quarter of a century."

MRS. HENRY GARNJOBST, past-president, Woman's Auxiliary, OSMS: To you, Clyde, from all of us, thanks. You have had our Auxiliary on your hands for 24 years and have furnished invaluable counsel and guidance for all our projects.

RICHARD B. DILLEHUNT, Dean Emeritus, Oregon Medical School: . . . during the 25 years that you have been secretary of the OSMS life expectancy has been extended 44 to 68 years . . . a signal achievement in the record of any man.

JOHN H. FITZGIBBON introduced Mr. Foley as the final speaker and in so doing presented a resolution from the House of Delegates which read: "You are hereby elected an honorary member of the Oregon State Medical Society." The toastmaster then handed Mr. Foley two keys to a brand new Pontiac sedan, gift of the Association.

CLYDE COWIE FOLEY: The Oregon State Medical Society is not indebted to me. I am the debtor. It has been my good fortune to spend my life in Portland with lads that I went to grammar and high school with, a pleasure that could not exist anywhere in foreign territory . . . Oregon now has more types of prepaid medical plans than any other state . . . is serving a total of 534,000 people . . . about a third of our population . . . Thanks to my 1400 employers and their wives . . . to Mr. Roscoe Miller for his four years' service as assistant . . . to Miss Evelyn Coburn . . . also the other employees of the Society . . . and particularly my wife, Eleanor . . . most important of all . . . who, like all ex-secretaries' wives and Auxiliary members, is a Medical Society widow.

I asked a newspaper reporter friend what I should use as a theme for my talk this evening. He said, "You've got 25. Do you want to try for 50?"

My answer is, "I want to try for 50."

Idaho and Washington Well Represented



1. J. D. Rankin, President-Elect of O. S. M. S., was in attendance with Mrs. Rankin. With them are Dr. and Mrs. W. W. Baum. Dr. Baum is a past president of O. S. M. S. Mrs. Baum is immediate past president of the Auxiliary to the O. S. M. S.

2. Among those at table 40 in the Grand Ballroom were DeNorval and Mrs. Unthank, paying their respects to the honored guest and notables in attendance.

3. Frank R. Menne, chairman, advisory committee, Sommer Memorial Fund, who presented commemorative scrolls to guest lecturers.

4. Herbert L. Hartley, left, editor of Northwest Medicine, with R. E. and Mrs. Rasmussen, Portland, and Dr. and Mrs. C. J. Klaaren, Moscow, Idaho.

5. Virgil S. Counsellor, Rochester, Minnesota, who received a commemorative scroll as a Sommer Guest Lecturer.

6. Delegates and guests from throughout the Northwest numbered 550, eight of them pictured above at table 55.

7. Eugene Rockey, Portland, left, and Donald V. Trueblood, Seattle, right, are members of the advisory committee of the Sommer Memorial Fund. Between them is Guest Lecturer Professor F. H. Bentley of Newcastle on Tyne, England, who received a Sommer commemorative scroll.

8. John H. Fitzgibbon, toastmaster, presided through a three-hour program. At 11:45 p. m. he turned the gavel back to Blair Holcomb, new president of the O. S. M. S.

9. Wm. J. Weese, at microphone, opening the 77th Annual Banquet of the O. S. M. S. honoring Clyde C. Foley. Weese becomes past president, yielding the gavel to Blair Holcomb.

10. J. D. M. Crockwell, Mrs. Anna M. Ramsdell and Thyra and Wm. Lockey enjoyed every minute of the program. Like hundreds of others, they came early for the cocktail hour in the Junior Ballroom, met scores of old friends and helped make the 77th Convention the biggest and best in the history of the Society.

Many Notables in Attendance at Banquet Honoring Foley



1. An animated group was John W. Cline, President, A. M. A., and Mrs. Cline and Dr. and Mrs. James Buckley, the former a past president of O. S. M. S.

2. From left are Mrs. Douglas McKay; Dr. Leslie Kent, Eugene; the Honorable Douglas McKay, Governor of Oregon, and Dr. and Mrs. Frank Menne.

3. Honored with her husband was Mrs. Clyde C. Foley, right, with Dr. Marlowe Dittebrandt.

4. Clyde C. Foley, Executive Secretary, O. S. M. S., receiving certificate of title and duplicate keys to his new Pontiac sedan, gift of the Society, from Toastmaster John H. Fitzgibbon.

5. Covering the convention for Northwest Medicine was Herbert L. Hartley, left, with John W. Cline and Mr. Foley.

6. And Her Honor the Mayor was there, Mrs. Dorothy McCullough Lee, standing at the left of her husband, Scott. They are with Mr. and Mrs. M. J. Frey.

7. Brunette quintuplets and all beautiful are, left to right, Mrs. G. Boylston, Portland; Mrs. Leon Ray, Portland; Mrs. Edward Dunn, Moscow, Idaho; Mrs. C. B. Menkel, McMinnville, Oregon; and Mrs. Douglas McKay, wife of the governor, Salem.

8. A Portland trio are Kenneth Livingston, left; Stanley Lamb and John Adams. Lamb is a past president of O. S. M. S.

9. D. W. E. Baird, center, has, as boon companion, Milton Murphy, left, and Charles Byrne. Baird is dean of the Medical School of the University of Oregon.

Notes from the Medical School

Recently approved grants from the Oregon Division of the American Cancer Society total \$22,585 for the year ending August, 1952, and represent continuation of cancer research programs underway at the medical school.

A donation of \$500 for the Max and Rose Tucker Foundation to assist in the work of Doernbecher Memorial Hospital for Children.

A gift of \$300 from the estate of Minnie R. Hayden for the Doernbecher Memorial Hospital for Children.

A donation of \$1,000 from the Oregon State Elks Association to be utilized for the operation of the Elks' Eye Clinic for children in the Department of Ophthalmology.

Access roads have now been completed at a cost of \$35,000 to the location of the new \$6,000,000 University General Hospital. Construction is scheduled to begin in early spring of 1952.

The Medical School's Department of Clinical Pathology with the cooperation of the Oregon State Advisory Committee on Laboratories and the Hygienic Laboratory of the Oregon State Board of Health gave a five-day refresher course in medical mycology and syphilis serology at the Medical School, September 10-14. Guest instructors from the U. S. Public Health Service Laboratories at Chamblee, Ga., were Dr. Libero Ajello and Ad Harris.

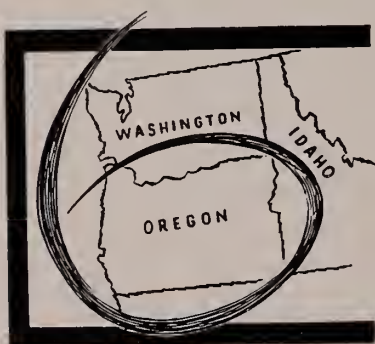
Oregon Association of Hospitals opened its annual fall meeting October 17 with a two-day session at Hotel Senator, Salem. Wesley G. Lamer is president of the association and also administrator of Physicians and Surgeons Hospital, Portland.

The panel of interesting speakers, announced by William Esson, chairman of the program committee, included Richard M. Jones, director of Blue Cross Commission of the American Hospital Association, Chicago, who made the initial address—"Blue Cross Plans and Hospitals." The Oregon Association of Hospitals is an affiliate of the American Hospital Association which sponsors Blue Cross.

Jones, formerly of Portland, coordinates the activities of 87 Blue Cross prepaid hospital plans throughout the United States, Canada and Puerto Rico, with an enrollment of over 41,000,000 persons. A graduate of Jefferson High School and an alumnus (1929) of the University of Oregon, Jones was once sportswriter on the old *Telegram*, later became Associated Press correspondent for the *Pendleton East Oregonian*. He was named national director of Blue Cross in 1947, after serving a year as director of public relations.

Highlights on the program of the two-day session were: "A Summary of Current Payment Policies by Third Parties," by Werner Hendrickson, assistant administrator, Emanuel Hospital, Portland; "Collection Methods and Problems," by J. D. MacEwan, manager, Portland Retail Credit Association; "Report on American Hospital Association Convention," by William Gahlsdorf, business manager, Salem General Hospital; "How the Banking Service Can Help Collections," by Norman W. Donelson and George Sheppard, assistant cashiers from the installment loan department of First National Bank of Portland; "Problems of Staffing and Operating the Community Hospital," discussed by Franklin J. Smith, administrator, Josephine General Hospital, Grants Pass; J. W. McAlvin, administrator, Douglas Community Hospital, Inc., Roseburg, and Fred Morris, administrator, Cottage Grove Hospital. Lawson McCall, assistant to Governor McKay, gave the principal banquet address. Dr. Robert Heilman, chief of the Emergency Medical Division of the Medical Department, Oregon State Civil Defense Agency, concluded the program with a talk on "Civil Defense."

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State Board of Pharmacy to Administer Uniform Narcotic Drug Law

House Bill 14 is now Chapter 22, Laws of the Second Extra Session Laws of 1951. It was passed as an emergency law and became effective October 1, 1951.

ABSTRACT

Narcotic drugs are defined as coca leaves, opium, cannabis, isonipocaine, amidone, isoamidone, ketobemidone, or any of their salts, and every other substance neither chemically nor physically distinguishable from them.

The law will be administered by the State Board of Pharmacy. No funds were appropriated for administrative purposes.

It provides that a licensed manufacturer or wholesaler may sell and dispense narcotic drugs, but only on official written order signed in duplicate by the person giving said order. Copies of such order shall be retained by the parties to such transaction for two years for inspection by any public officer or employee engaged in enforcement of this law. Narcotic drugs sold to a person in charge of a hospital may be used only by or in that hospital.

An apothecary, in good faith, may sell and dispense narcotic drugs to any person upon a written prescription of a physician, dentist or veterinarian, dated and signed by the person prescribing on the day when issued and bearing the full name and address of the patient for whom or the owner of the animal for which the drug is dispensed and the full name and address and registry number of the person prescribing when it is required under the federal narcotic laws that he be so registered. The person filling the prescription shall write the date of filling and his own signature on the face of the prescription and it shall be filed for two years so as to be readily accessible for inspection by authorized persons.

Aqueous or oleaginous solutions in which narcotic drugs do not exceed 20 per cent may be sold to physicians, dentists or veterinarians in quantities not exceeding one ounce at any one time.

A physician may prescribe, administer and dispense narcotic drugs or cause same to be administered by a nurse or interne under his direction and supervision provided that unused quantities, no longer required by the patient, be returned to the physician. Medicinal preparations that contain in one fluid ounce or one

avoirdupois ounce not more than 1 grain of codeine or any of its salts are excluded from these restrictions provided they contain other medicinal qualities and are not designed to evade the provisions of this law.

Every physician, dentist or veterinarian must keep a record of the dates, quantity, character and potency of narcotic drugs received and used or lost or stolen except when the quantity used by any one patient in any 48 consecutive hours does not exceed four grains of opium, or one-half grain of morphine or any of its salts, or one-fourth grain of heroin or any combination of narcotic drugs not exceeding the pharmacologic potency of any one of the drugs above named.

Labels on prescriptions shall show the name, address and registry number of the apothecary and the prescribing physician and the name and address of the patient together with such directions as may be stated on the prescription.

Conviction for violation of any provision of this law shall constitute grounds for revocation of license by the appropriate licensing board which also on proper showing and for good cause may reinstate. Conviction for violating any provision of this law is punishable by a fine not exceeding fifty thousand dollars and by imprisonment in the state penitentiary for a term of not less than ten years except that for the first offense the court may impose a fine of not to exceed one thousand dollars or a sentence not to exceed one year in the county jail or both.

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Grass Roots Opinion Sought on Rural Health Problems

How concerned are Washington's rural people with the special health problems posed by living on farms in small towns?

A "grass roots referendum" is being carried on this month by some of the leading rural organizations to find out just what the man on Main Street thinks. If sufficient interest is shown, farm and health groups are ready to plan a state-wide conference on rural health problems to help communities help themselves solve these problems.

There's no denying that in parts of this state some rural people have to drive fifteen or even twenty-five miles to get to a doctor. In some places, the hospital is even further away.

Doctor-sponsored prepayment plans have a substantial membership in towns and cities—but out in the country enrollments are still pretty thin.

In Winthrop, the community has bought a completely equipped trailer to enable a dentist to serve a large rural area. But there's still trouble getting a dentist because the trailer is snowbound for so long each year.

In other places, the shortage is public health services. Several counties have only a part-time health officer and perhaps a public health nurse or two, whose services must be spread pretty thin.

On the other hand, it's not a one-sided proposition. There are good reasons for the shortages.

Just as country people today tend to shop more and more in distant cities, so are they going farther afield to get medical service. Practices are declining in country towns whose population has stayed the same—patients are going to the cities to seek specialists.

To get good public health services, the community must be willing to support the program of a full-time health department and be willing to foot the bill.

Rural people must understand that in order to attract needed professional people—be they physicians, dentists, nurses or others—there must be economic opportunity and at least minimum equipment and facilities.

Hospitals today cost \$15,000 to \$20,000 per bed to

build—and operating "in the black" is even more of a problem. Some hospitals in this state which have operated at capacity for years are now seeing empty beds as the result of shorter average patient stays.

In summary, there are many real problems in bringing together today's "supply" of medical and health services with the "demand" that exists in rural areas.

At the American Medical Association's fifth national conference on rural health last year, a summarizer stated:

"The answers to these problems will not be found in Washington, or in Chicago, or even at this conference, but they will be worked out in local communities by informed individuals working together."

With this sort of philosophy in mind, a group of Washington farm and health groups met September 27 to see if there was a genuine concern on the part of rural communities here about the health problems they face. Mr. Howard Barnes, public relations director, represented the Washington State Medical Association at the meeting, called at the suggestion of the Washington State Health Council. The group decided to poll rural people direct to get first-hand opinion.

Hundreds of granges, local farm bureaus, rural women's clubs, extension service groups, local health councils and others will fill out a questionnaire this month. The results will be presented at another meeting of the state-wide groups about December 1.

If the reaction warrants, plans will be laid for a state-wide rural health conference where farm and health groups can meet together, discuss the basic issues and present "success stories" from communities which have been able to solve some of the problems.

The groups who attend the September meeting include, in addition to the Medical Association, the State Dental, Nurses' and Hospital Associations, the University Medical School, the Association of Local Health Councils, the State Health Department, the Washington State Grange, Extension Service, Farm Bureau Federation, Farmers Union, State Federation of Women's Clubs and the State Department of Public Instruction.

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By RALPH W. NEILL

Executive Secretary, Washington State Medical Association

("Medical Economics," the official membership bulletin of the Washington State Medical Association, heretofore mailed from the office of the secretary, will hereafter be published monthly in the Washington Section of NORTHWEST MEDICINE. It will continue to be written and edited by Mr. Neill.)

NEW NARCOTICS CODE. The Special Session of the State Legislature in August passed a new narcotics code which deserves close attention by practicing physicians. Elsewhere in this issue is a brief abstract of the new law. Suggestion for County Society programs—call in your local prosecutor for explanation of the law and information on how best to comply with the new statute.

NEW TREND INDICATED. Indiana's attempt to eliminate the secrecy clause in federal requirements for relief rolls has spread to other states, to organizations and even to the federal government. National legislation has been introduced to repeal this regulation and hearings will be held. The Washington State Senate passed a similar measure during the regular session this year, but it died in the less conservative House of Representatives. State governors in a Tennessee conference recently unanimously approved a move to reserve to the states the right to decide whether their relief rolls shall be made public.

(In Olympia, the Social Security Department announced recovery of \$430,000 from welfare recipients who were paid illegally or overpaid since January 1. Although jobs were generally plentiful, a total of \$1,151,284 was fraudulently obtained by 18,000 chiselers from state jobless insurance funds in three months of this year, the federal Labor Department reported. Over the 12-month period ending on June 30, 65,000 individuals collected from various states more than 4½ million dollars in jobless checks by fraud.)

In Ephrata, Wash., on October 3, Grant County farmers asked the government to stop giving them \$99,000 annually for conservation practices. Farmers said payments were a "waste of taxpayers' money and a demoralizing influence." In the national capital, the American Farm Bureau Federation, largest farmer group, is in full revolt, charging the Department of Agriculture, through county employees, is trying to ram a set of ready-made policies (Brannan plan) down the farmers' throats.

NATIONAL LEGISLATIVE DIGEST. The Federal Aid to Medical Education measure, Senate Bill 337, was re-committed to committee and it is highly unlikely the committee will reconsider it this session of Congress.

Proposal for allowing deduction of most medical expenses, including health insurance premiums, from taxable income was defeated in the Senate, the opposition contending losses in taxes would amount to from seven hundred million to as much as two billion dollars. . . . Newly introduced H. R. 4473 proposes



RALPH W. NEILL

taxpayers be permitted to deduct from adjusted gross income medical expenses, including health and accident insurance premiums, up to \$1,250 per year for single persons and \$2,500 for the taxpayer and dependents. . . . A Senate measure, S. 2171, just proposed, would authorize grants enabling states to survey, coordinate, supplement and strengthen existing health resources so hospital and medical care may be obtained by all persons. . . . House committee hear-

ings on the \$47 million federal aid to nursing education bill, H. R. 910, have been concluded. A. M. A.'s position on nurse supply is, there is a shortage of nursing service, but not an actual shortage of nurses, as there are some 200,000 nurses not now practicing who could be counted upon in emergencies. . . . Senate Finance Committee amended new revenue bill to allow taxpayer over 65 to deduct medical expense for him and spouse from taxable income. . . . Congress is in a quandary over drug bills now under consideration. Marjorie Shearon contends the Senate bill is a fight between the Federal Food and Drug Administration and the National Association of Retail Druggists for control of the drug industry and in any result would further the nationalization of medicine; and in the case of the House bill, it is an attempt by Ewing to socialize medicine by a new back door.

NEED A HOSPITAL? "Does Your Community Want a Hospital?" is the title of a booklet published by the State Department of Health and recently sent secretaries of all county societies by the State Association. Defense Production Administration has allowed more steel and copper for such purposes, which may cause a

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(Continued from Page 869)

new splurge in applications for Hill-Burton hospital money.

STATE CONVENTION BOUQUET. Whitaker and Baxter, A. M. A.'s Educational Campaign directors who were speakers on the State Convention Public Relations Program, were very enthusiastic about our Convention. In a joint letter to the Central Office, they said, "We both thought your Convention one of the most enthusiastic and most effective medical meetings we have attended in our three years with the A. M. A." (If that is in any sense true, Whitaker and Baxter certainly contributed handsomely toward that accomplishment.)

A. M. A. MEETING ON COAST. The Interim Session of the A. M. A. is scheduled for Los Angeles on December 2-7, affording West Coast physicians an opportunity to take in an interesting and worthwhile meeting. The scientific sessions and the House of Delegates are programmed from the 4th through the 7th. The two days prior to those events are filled with public relations and other conferences. Those thinking of attending, and there should be many from Washington, should make their reservations immediately. Instructions will be found in *J. A. M. A.*

WOULD KEEP A. M. A. HOME. There's a move afoot, started by Ohio State Medical Association, to prevent the A. M. A. from holding its interim sessions in the "sticks." A resolution being circulated by the Ohio medicos would confine the December meetings to the city where A. M. A. makes its headquarters. Expense involved by moving records from Chicago to the Interim Session city, and inconvenience and expense incurred by doctors in far-off places in attending the meetings were given as sufficient reasons for the proposed change. Forgotten in this move is the fact the A. M. A. House of Delegates, composed of doctors from all parts of the country, voted to hold Interim Sessions in "grass roots" areas in order to bring the A. M. A. to the home-town physicians. Necessarily, the annual A. M. A. Conventions are held in eastern cities, principally, making it most inconvenient for western residents to attend. Only once in every three or four years is the convention held in San Francisco, when Coast physicians can conveniently attend. Interim Sessions held in various parts of the country seem like a good idea.

HEALTH PROTECTION GROWS. Hospital, surgical and medical expense coverage continues to show increased acceptance by the public, according to A. M. A. findings. Hospital coverage gained 17 per cent to a total of 76,960,000 during 1950, surgical coverage increased 32 per cent to 54,477,000 and medical coverage gained 28 per cent to a total of 21,589,000 subscribers. Insurance companies reported a gain of one million persons through their individual policies. At least half the nation's population is now covered in some form or other by voluntary health protection. Complete report on prepaid coverage may be obtained from A. M. A.'s Council on Medical Service.

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EXECUTIVE SECRETARY HONORED. Well-earned tribute was paid Mr. Clyde C. Foley, who has completed twenty-five years as executive secretary of Oregon State Medical Society, during the Society's Annual Convention. (We didn't dream they could live that long.) Known to the rest of us as the "dean" of medical executive secretaries, Clyde holds the respect of the entire fraternity and it is with great pleasure we learn he has been honored by the Oregon physicians. The first twenty-five years are the hardest, Clyde. Your second quarter-century of service should be easy. Here's to you.

SCRAPING THE BARREL. The government payroll costs each family \$400 annually . . . Socialization of life insurance would be required by a global treaty given preliminary approval by the International Labor Organization . . . At least 11 states have some type of medical student loan or scholarship fund requiring rural practice . . . The Student American Medical Association is coming of age—it has abandoned its mimeographed bulletin for a Journal . . . Awakening to the threat of socialization of the practice of law, the California bar has proposed a counter-offensive . . . The A. M. A. will revise its 12-point program. (Remember it?) . . . Two State Medical Associations, Wisconsin and Pennsylvania, each have pledged a quarter of a million dollars toward medical education. Wisconsin will help needy students through medical school who locate in that state, and Pennsylvania will contribute its fund to the A. M. A. medical education fund. Both funds will be raised by subscription campaigns. (Nice going). . . A total of 26,191 medical students were enrolled in 79 approved schools in U. S. for 1950-51 academic year, an increase of 1,088 or 4.1 per cent over the previous year.

BASIC SCIENCE EXAMS UPHELD. The State's Supreme Court upheld the Basic Science Board against chiropractors who claimed the examinations were not "elemental" as required. Having failed to break down the Basic Science Law through the legislature and in the courts, the chiropractors now are reported to be joining labor unions in an attempt to gain support for their attacks upon the law. Not many labor units will be led astray as was one, which adopted a recommendation of its chiropractic-influenced educational committee in criticizing the "methods employed by medical men who have uncontrolled authority over the examination of chiropractors." Medical Societies would do well to carry on an educational program with their local labor leaders on the merits of basic science examinations for all those who practice the healing arts. Simply, the law protects the public from all unqualified practitioners.

MEDICAL CARE CHARGES. Consumers' Price Index shows a 72 per cent rise in living costs since 1939, compared with a rise of only 48 per cent in medical care prices. Physicians' fees rose 40 per cent, while hospital room rates increased 135 per cent.

Spotlight on Service

Below are a few news notes on some typical activities, representing a cross-section of the public service being rendered by physicians. The Washington State Health Council, 905 Second Avenue Building, Seattle, prepares these notes for NORTHWEST MEDICINE and welcomes any contributions on activities in your area.

Medical Representative Discusses Rural Health

Mr. Howard Barnes, public relations director for the State Medical Association, attended a meeting last month in which representatives of leading farm and health groups talked over the possibility of holding a state-wide conference on rural health problems. The meeting was called by the Washington State Health Council, which had been requested to take leadership in exploring the need for such a meeting.

Discussion centered around whether the rural people of this state are genuinely concerned about health problems and if there would be wide interest for such a meeting if held. As a result, participating organizations are sending out a "grass roots" questionnaire, and another meeting will be held about December 1 to discuss the returns.

L. E. Powers represented the University medical school at the conference. Other participating health groups included the State Dental and Nurses' Associations, the State Department of Health and the Washington Association of Local Health Councils.

Heart Men to Address County Societies

Six physicians are scheduled to address county medical societies throughout the state on management of arteriosclerosis, under auspices of the Washington State Heart Association.

The doctors are William E. Watts, Robert L. King, Robert A. Bruce, Kazimir B. Skubi and Donal A. Sparkman of Seattle and Merritt Stiles of Spokane.

Engagements booked so far include Snohomish County, October 2; Clallam County, October 15; Skagit County, October 23; Kittitas County, November 6; Pierce County, November 13; Okanogan County, November 29, and Benton-Franklin Counties, December 12.

The county talks are a "return engagement," attesting to the success of last spring's series on rheumatic fever. They are the keystone of the Heart Association's professional education campaign.

Bellingham Pediatricians Discuss Use of Grid

Two Bellingham pediatricians, Julius K. Neils and Frank L. Tabrah, told public health workers of the state of their experiences with the Wetzel Grid last month. The grid is a device used to chart normal growth and development for each individual child. It is becoming widely used by schools in connection with their health service programs. The two physicians discussed the use of the grid as seen by the private practitioner.

The occasion was the sixteenth annual meeting of the Washington State Public Health Association at the Bellingham Hotel.

John D. Fouts, health officer, greeted the delegates and was toastmaster at the banquet. H. L. McMartin, Snohomish County health officer, participated in a panel discussion on health education and J. A. Kahl, acting state director of health, spoke on medical and health services in civil defense. J. L. Jones discussed the nursing home inspection program.

Physician Helps Review School Health Services

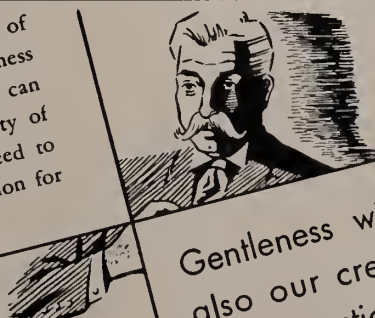
Michael J. Buckley of Bellevue is a member of a committee of the Washington State Health Council set up to review and make recommendations on schools' health-service programs. He represents the State Medical Association on this research committee, which is examining present practices, discussing which services ought to be provided to school children and recommending a standardized plan for guidance of schools throughout the state.

Bernard Bucove, Thurston-Mason County health officer, is also a member of the committee.

Tells Health Needs of Aging

K. K. Sherwood, superintendent of Georgetown Branch, King County Hospital, participated in a panel discussion on "Meeting the Health Needs of Our Aging Population" last month at the University of Washington. The discussion was one in a series of public health seminars, sponsored by the university, the state and Seattle-King County Health Departments.

DANIEL DEFOE (1661-1731) gave this bit of wise advice: "Try all methods of gentleness and patience which a forbearing temper can dictate or which prudence and the safety of his debt will allow, before you proceed to prosecution. Proceed with all due caution for the reputation of the debtor."



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Barnes Discusses Public Relations in Washington State Medical Association

Interest ran high on the subject of public relations at the recent Washington State convention, and reports by Whitaker and Baxter, A. M. A. public relations team, were received with great enthusiasm. Also of great interest and importance was the discussion by Mr. Howard Barnes, public relations representative for the Washington State Medical Association. In the report which follows, Mr. Barnes details the correlation of the Washington Association's program with the program being carried out by the A. M. A.:

Public Relations in W. S. M. A.

By HOWARD L. BARNES

Perhaps it is the long training in certain sciences and the skillful cultivation of certain arts involved in the practice of medicine which prepared doctors to gain a ready grasp of public relations principles and techniques. That this is so is indicated in the scope and effectiveness of their recent nationwide success in meeting the threat of the "socializers" to engulf the medical field. The timely and wise selection of counsel, the determined and vigorous, financial, organizational and personal support of a program and the present determination to retain a working team to offset or meet potential future threats, is proof of their aptness in this relatively new and obviously essential activity.



HOWARD L. BARNES

Perhaps it was the high sense of responsibility and accountability which grow out of the doctor's relationship to his patient, or the clear insight into human behavior which stems from such a relationship, or the dominant humanitarian attitudes which are so much a part of the doctor's ethics and training which attended the success of his first major venture into a concerted public relations activity.

Doctors know something about meeting emergencies. In the management of their patients' medical problems they meet them daily. They know the need of accurately weighing alternatives. They know the necessity of meeting emergencies with courage and decision. They also know what "early recognition" and "prompt attention" can accomplish toward keeping everyday problems from becoming emergencies. Doctors have been quick to discover that these principles employed in the field of medicine are equally applicable in public relations.

There is nothing new about public relations as such—except in the sense that it is becoming an organized body of knowledge representing the administrative philosophy of an organization. It is a com-

posite of many little things making up the sum total of all the impressions made by the organization itself and by the various persons connected with it.

Today, most of the state associations or societies have definite public relations programs with specific budgets and specialized personnel to carry such programs forward.

An outline of W. S. M. A.'s program of public relations is reported elsewhere in the proceedings of this convention. The present report will concern itself with selected activities which have been given some measure of priority because of sheer defensive necessity.

Although this association concerns itself with nation-wide problems in its field, some of its most pressing public relations problems are more localized and center particularly with the administrative and legislative branches of state government.

The violent fluctuations in the scope of the state's welfare medical program are creating a series of exceedingly difficult public relations situations.

The struggle between free spending and conservative factions in the Legislature and the shifting balance of power between houses, parties and smaller groups have created highly unstable and unpredictable situations. Matters which vitally concern health care may be advanced or retarded on the basis of these underlying conflicts or may become completely lost in the shuffle of issues between committees, houses, sessions and courts. Within the Legislature itself, the trading of votes, the search for support and the leveling menace of compromise may mitigate against the consideration of many important issues on their merits.

How is the State Association planning to cope with these situations?

The first and most pressing need, of course, is to maintain continuing and repeated contact with members of the Legislature in order that the leadership and a majority of individual legislators will at all times, and on all medical issues, know the doctor's position and the probable effect of proposed or threatened action upon sound medical practice and good health care.

But this is not enough.

For one reason or another certain legislators have a deaf ear when approached by representatives of the medical profession. It may be a matter of personal prejudice, adherence to an authoritarian ideology, belief in some unconventional philosophy or mode of treating sick people or it may be on the basis of political or personal commitments or alliances previously made.

Whatever the cause, it becomes the clear responsibility of the members of the medical profession to take full cognizance of these situations and work vigorously for the replacement of such members of the Legislature with people who will have an open mind on matters involving health care. This can be done, and is being done, by pointing up both the issues and the vital needs of individual physicians to

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clearly that the electorate will be fully informed on the position of Legislative aspirants on medical issues. Practical considerations dictate in which areas such energies are focused.

The medical profession is not alone in the fight to halt the advance of socialism. Nor is it alone in its determination to continue those regulatory functions of the law which are designed to help maintain high standards of health care. There are many allies in both parties and in many fields of endeavor whose united efforts should be more than equal to the task ahead. The systematic marshalling of these forces should closely parallel the effective development of our present public relations program. The degree of success will depend very largely upon the amount of interest and careful attention given to this program by the doctors themselves.

A study of votes cast in all districts of the state in recent elections has been made. A detailed study of the voting record of many legislators on medical and other issues is in preparation. The results of these studies will be made available in the areas which they involve. This information will be useful to the public relations and other committees of the county societies and the auxiliaries.

Many outside contacts have been made to determine the views and counsel of various interested individuals and representative groups in many sections of the state. Through these steps a more effective channeling and coordination of our efforts should be obtained.

Those facets of the over-all public relations program which are here reported are only a small part of a very broad and comprehensive outline of activity. Your public relations committee has done a fine job in preparing such an outline.

From here on the job is one of grinding detail and contact for staff, and continuing determined interest by the members of the medical profession and their friends and allies.

There are widely different views concerning the proper scope and function of a public relations program in W. S. M. A.

Some consider that it is simply and only a matter of professional relations. Others see it as purely a matter of publicity. Still others are thinking in terms of politics or speech-making or any one of the many divisions of activity normally involved in the day-to-day operations of the association.

To some a good public relations program means keeping in the spotlight, while others may seek a prosperous obscurity.

Definitions are a dime a dozen from likening public relations to love-making or fortune telling or the gentle art of letting the other fellow have your way.

A sound professional view is that a proper program of public relations may in one way or another include all of the aspects of the organization's relations with the various publics with which it or its members or staff may come in contact in a business, personal or professional way. Your public relations committee has emphasized that "Good public relations depend upon good works—not so much on how widely we are known, but on how favorably we are known."



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Because of the volume of contact and the intimate nature of that contact, the doctor's own responsibility and opportunity for maintaining and extending good public relations with his patients is of unparalleled importance. His office procedures and personnel should be subject to periodic review from a public relations standpoint. After all, your associates and employees are "experts" in the public eye, on matters involving the operation of your office. On a broader scale this applies to your medical bureau, hospital and other associations as well.

Other factors in the broad program include careful attention to medical economics with particular care in avoiding excessive fee charges; the extension of voluntary prepayment health insurance; prompt attention to grievances; improving emergency call procedures; and constructive participation in carefully selected and worthy civic and government programs in the health field.

The fact remains that we are going to have extensive relations with various publics whether we give specialized attention to them or not. The attacks which have been made against the free practice of medicine by certain politicians and a small but vociferous group of medical malcontents and the cultists can no longer be treated lightly. They must be met on every front and in every area. This requires that the doctors and their friends must take and keep the initiative in halting the planned and heavily financed attacks which have been advanced under high political sponsorship.

Since marshalling our forces a few important battles have been won but the war goes on. Make no mistake about it—the months ahead will require the best thought and effort that all of us can give to

keeping not only medicine but America free.

To summarize briefly:

There are two main problems which must of necessity be given first consideration in the development of the W. S. M. A. public relations program if good results are to be accomplished in reasonable time.

The first has to do with government and especially the Legislature where, despite the many capable and sound people who are serving in it, there is a dangerously large number of members who are openly prejudiced or antagonistic. It is important to vote and work for their removal.

The second concerns the doctor's responsibility as an individual to maintain the best relations possible with his patients, his associates and the general public. I am sure that every doctor will find the outline prepared by your public relations committee under the chairmanship of Dr. Frank H. Douglass of outstanding value as a guide to better public relations.

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Clallam County Society	Second Tuesday—Port Angeles, Sequim President, T. W. Madsen Port Angeles	Secretary, J. J. Fairshier Port Angeles
Clark County Society	First Tuesday—Vancouver President, D. R. Loree Vancouver	Secretary, F. M. Butler Vancouver
Cowlitz County Society	Third Wednesday President, H. H. Minthorn Longview	Secretary, F. D. Morrison Longview
Groys Horbor County Society	Third Wednesday—Aberdeen President, W. H. Hardy Montesano	Secretary, M. C. Lindell Montesano
Jefferson County Society	President, C. M. Schail Port Townsend	Secretary, H. G. Plut Port Townsend
King County Society	First Monday—Seattle President, D. Metheny Seattle	Secretary, F. A. Tucker Seattle
Kitsop County Society	Second Monday—Bremerton President, H. A. Barner Bremerton	Secretary, F. Rosendale Bremerton
Kittitas County Society	First Tuesday—Ellensburg and Cle Elum President, W. E. Nawrocki Cle Elum	Secretary, A. H. B. Pedersen Ellensburg
Klickitor County Society	President, J. R. Rehal Stevenson	Secretary, W. H. Wolff White Salmon
Lewis County Society	Second Monday—Centralia and Chehalis President, G. W. Kling Centralia	Secretary, H. Y. Bell Centralia
Lincoln County Society	President, E. R. Salter Davenport	Secretary, J. E. Anderson Wilbur
Okonogon County Society	President, T. P. Conners Tonasket	Secretary, B. J. Webster Omak
Pacific County Society, Third Thursday	President, O. R. Nevitt Raymond	Secretary, J. C. Proffitt South Bend
Pierce County Society	Second Tuesday—Tacoma President, J. F. Steele Tacoma	Secretary, G. C. Kohl Tacoma
Skagit County Society	Fourth Monday President, R. R. Rueb Concrete	Secretary, R. M. Hoag Concrete
Snohomish County Society	First Thursday—Everett President, W. V. Meyer Everett	Secretary, R. J. Wescott Everett
Spokane County Society	Second Thursday—Spokane President, W. W. Henderson Spokane	Secretary, J. B. Plastino Spokane
Stevens County Society	President, C. M. Canning Colville	Secretary, M. B. Snyder Chewelah
Thurston-Moson Counties Society	Fourth Tuesday—Olympia President, R. Highmiller Olympia	Secretary, H. B. Frank Shelton
Walla Walla Valley Society	Second Thursday—Walla Walla President, M. W. Tompkins Walla Walla	Secretary, L. O. Carlson Walla Walla
Whitcom County Society	First Monday—Bellingham President, H. L. Trimmingham Bellingham	Secretary, A. B. Watts Bellingham
Whitman County Society	Third Wednesday—Colfax President, M. K. Turner Pullman	Secretary, W. S. Butts Pullman
Yakima County Society	Second Monday—Yakima President, R. D. McClure Yakima	Secretary, W. H. Gray Yakima

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"Friend or Foe"

The recent annual meeting of the Idaho State Nurses Association brought rather sharply into focus the picture of the unusual relationships which at present exist between the medical and nursing professions.

Attention was called to these existing conditions by the publicity in the daily press occasioned by the refusal of the Nurses Association to go on record as either favoring or disapproving the socialization of the practice of medicine.

The philosophy of such a middle-of-the-road, fence-straddling policy appears to have arisen following similar action by the American Nurses Association in San Francisco last year. There was repeated reiteration of the statement, "Nurses must provide the best care for patients regardless of the system of medical care."

Policies and attitudes such as these are not conducive toward improving nursing care or elevating the standards of the nursing profession.

The practice of nursing is so closely integrated with and a part of the practice of medicine, that any lowering of the standards of the practice of medicine as would occur were Mr. Ewing's ideas and proposals

adopted would mean an immediate decline in the present high standards of the practice of nursing.

Good nursing is unequivocally dependent upon good medical care. The decline of one will mean the downfall of the other.

If, therefore, the Nurses Association is sincere in its statements that its only wish is to provide the best nursing care possible for patients, then there can be and should be no middle-of-the-road course. Only an all-out effort by each and every nurse to retain absolute freedom in the practice of medicine will assure the nurses of the future the opportunity to advance their profession.

The fallaciousness of the present course should be forcibly brought to the attention of all practicing nurses. None can do this better than can the physician who has daily contacts with this group.

It should become the immediate personal duty of each and every physician to discuss these problems with his working associates in the nursing profession.

Positive action against socialization—not neutrality—is the only hope for the survival of the nursing profession.

The North Idaho District Medical Society met at the Bollinger Hotel, Lewiston, Idaho, on September 19, 1951. The meeting was called to order by Dr. Roy W. Eastwood, president. Thirty-two members were present. Minutes of the June meeting were read and approved.

Dr. Eastwood also gave a report to the Society regarding his trip to Seattle to attend a meeting of doctor members of the Medical Service Bureau in that city. On the basis of his report it was moved by Dr. Clyde Culp and seconded by Dr. A. J. White that a committee be appointed to determine a minimum fee schedule for the members of this society. Following an active discussion, the motion was carried and Dr. W. H. Pierce was appointed chairman. Drs. E. J.

Baldeck and John Ayers are the other members.

A discussion was held concerning the subject of night calls and the fee to be charged. No decision was reached.

The scientific portion of the meeting consisted of two films on ACTH loaned by the Armour Laboratories. The first film was entitled "The Physiologic Basis for Action of ACTH in Human Beings." The second was "The Therapeutic Use of ACTH in Human Disease."

John H. Tiernan, administrator of the new Bannock Memorial Hospital, Pocatello, took office as president of the Idaho Hospital Association during the annual meeting of hospital representatives held in Pocatello

September 25-26. He succeeds Mr. J. C. McGilvray, administrator of the Magic Valley Memorial Hospital, Twin Falls.

Mr. John Sundberg, administrator of the Caldwell Memorial Hospital, was named president-elect.

Participating in a panel discussion during the meeting was Dr. C. A. Terhune, Burley, member of the state medical association's Professional Relations Committee, and Dr. Milton T. Rees, chief of staff, the L. D. S. Hospital, Idaho Falls.

Principal speakers at the hospital session included Dr. Anthony J. J. Rourke, superintendent, Stanford University Hospital, San Francisco, and president-elect of the American Hospital Association, and Mr. C. E. Wonnacott, administrator, L. D. S. Hospital, Salt Lake City, president-elect of the Western Hospitals Association.

State Board of Medicine

During the past month, five temporary licenses have been issued. Applying for and receiving permits were:

Blaine H. Passey, Rexburg. Graduate of the University of Utah College of Medicine, Salt Lake City. General Practice. T-13.

Eva McGilvray, Medical Arts Bldg., Twin Falls. Graduate of Rush Medical College, Chicago. Pediatrics. T-14.

Don Frederick Kimmerling, Altadena, Calif. (Planning to open in Idaho Falls.) Graduate of Yale University School of Medicine, New Haven. Internal Medicine. T-15.

Calvin Charles Rush, 518 Eastman Bldg., Boise. (Jones Clinic.) Graduate of Pittsburgh Medical School. Ophthalmology. T-16.

Claude Ferdinand Peters, Hailey. Graduate of University of Nebraska College of Medicine, Omaha. General Practice. T-17.

Idaho State Medical Association Component Societies

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Montpelier	Groce
Bonner-Boundary Counties Society	
President, H. Petersen	Secretary, H. G. Lawson
Sandpoint	Priest River
Idaho Falls Society	
President, D. H. Smith	Secretary, H. R. Fishback, Jr.
Idaho Falls	Idaho Falls
Kootenai County Society	
President, R. T. Henson	Secretary, C. G. Barclay
Coeur d'Alene	Coeur d'Alene
North Idaho District Society	
President, R. W. Eastwood	Secretary, J. H. Bouman
Lewiston	Lewiston
Shoshone County Society	
President, L. B. Hunter	Secretary, C. I. Gibbon
Wollace	Kellogg
South Central District Society	
President, J. W. Creed	Secretary, E. T. Rees
Twin Falls	Twin Falls
Southeastern District Society	
President, R. B. Hegsted	Secretary, M. M. Graves
Pocatello	Pocatello
Southwestern District Society	
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Prepaid Medical Plans Greatest Bulwark Against Socialized Medicine

Further improvement and expansion of prepaid medical plans is the greatest bulwark against socialized medicine, declared John W. Cline, president of the American Medical Association, in his address to the delegates and guests at the Oregon State Medical Convention banquet Friday evening, October 12, at the Multnomah Hotel.

Cline briefly reviewed the history of prepaid plans and stated that no insurance has advanced as fast as prepaid insurance and that organizational and coverage efforts should not be relaxed until the Association goal of 80 million subscribers is reached.

Physicians and societies must pay attention to public relations.

Cline advised physicians to learn the full and complete story of the American Medical Association . . . its buildings, investments and personnel . . . reciting that 140,000 doctor members own a nine-story structure where 800 people are employed full time to bring order out of chaos.

Some doctors charge too big a fee. Sometimes no doctor is available for calls. Sometimes common courtesy is lacking, Cline stated.

The best remedy is an active grievance committee whose work is fully publicized so that the people may know what is going on.

Cline thought that more doctors should participate as individuals in politics and public affairs. They should give honest and helpful assistance to the working press. They must convince society of the correctness of their ethics, program and methods.

The speaker dwelt at length on the threat of socialized medicine.

"When we think back three years ago it was predicted that socialized medicine would be thrust upon us despite any opposition we might develop. In 1948 we organized against it and today public opinion is crystalized in opposition to it.

"A great change has taken place. Over 90 per cent of newspapers are against socialized medicine. Forty-five per cent of labor is opposed to socialized medicine, 27 per cent is for it and 28 per cent doesn't know.

"We are opposed, bitterly opposed, to socialized medicine. Let us not permit us to accept even just a little bit of socialized medicine.

"Our battle is not over. It is only half done and there is no room for complacency. The first half of the 20th century we know as the golden age of medicine. Now we are at the threshold of even far greater opportunities. And these opportunities are the great responsibility of our future," concluded the president.

Kenneth G. Whyte Named Representative to Civil Defense Conference

Kenneth G. Whyte of Seattle, chairman of the W. S. M. A. Committee on Civil Defense, was named by the Executive Committee as the official representative of the Association to attend a medical civil defense conference on November 9-10 in Chicago. Frank G. Leibly of Seattle was named alternate.

The conference in the Palmer House will be held under the joint sponsorship of the American Medical Association, the American Hospital Association and the Association of State and Territorial Health Officers. State public health officers, chief hospital administrators and representatives of the state medical societies will meet with government civil defense authorities.

Among the topics to be discussed will be biological warfare, national blood program, survival during and after atomic attack, casualty medical records and community organization of lifesaving teams of doctors, nurses, hospitals and others to meet disaster.

The speakers will include Millard F. Caldwell, Jr., federal civil defense administrator and former governor of Florida; Col. William L. Wilson, assistant civil defense administrator in charge of health and welfare; Dr. Norvin C. Kiefer, director of special weapons defense for the Federal Civil Defense Administration, and Dr. Herman Hilleboe of Albany, New York state

health officer who planned and set up New York's medical civil defense program.

Dr. James C. Sargent of Milwaukee, chairman of the A.M.A. Council on National Emergency Medical Service, will preside.

Robert C. Murphy of Tacoma spoke to the annual meeting of the Washington Society for Mental Hygiene in Yakima last month, outlining the role of a mental-hygiene clinic in a healthy community. Murphy and C. I. Hood, Yakima psychiatrist, also took part in a symposium on mental health clinic practice.

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Office of Salary Stabilization lists the following as not exempt from salary controls:

Physicians employed by corporations such as insurance companies where their services are performed elsewhere than in a licensed hospital; physicians employed to write medical literature or do research for the manufacture of pharmaceuticals; physicians employed by other physicians carrying on their practice,

and such auxiliary branches of the medical profession as pharmacists, nurses, optometrists, dental technicians or chiropractors.

The office also states that a physician is employed in a professional capacity and therefore not subject to wage controls, if he performs work which requires application of his medical knowledge and exercise of discretion or judgment and which is predominantly intellectual and varied in character.

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Prize Awards Being Offered for Essays

Of interest to many physicians are the valuable prize awards being offered by the American Society for the Study of Sterility and the American Urological Association, for essays in related fields.

Research in field of infertility: The American Society for the Study of Sterility announces the opening of the 1952 contest for the most outstanding contribution to the subject of infertility and sterility. The winner will receive a cash award of \$1,000 and the essay will appear on the program of the 1952 meeting of the Society. Essays submitted in this competition must be received not later than March 1, 1952. For full particulars concerning requirements for this competition, address the American Society for the Study of Sterility, 20 Magnolia Terrace, Springfield, Mass.

Urology award: The American Urological Association offers an annual award of \$1,000 (first prize of \$500, second prize \$300 and third prize \$200 (for essays on the result of some clinical or laboratory research

in Urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Chalfonte-Haddon Hall, Atlantic City, N. J., June 23-26, 1952.

For full particulars write the secretary, Charles H. de T. Shivers, Broadwalk National Arcade Building, Atlantic City, N. J. Essays must be in his hands before February 15, 1952.

Martzloff Delivers Bacon Lecture

Karl H. Martzloff of Portland was accorded the rare privilege of giving the 1951 Bacon lecture at the University of Illinois but in so doing missed the sessions of the Oregon State Convention, arriving home on Friday, October 12. Dr. Martzloff is president of the board of trustees of NORTHWEST MEDICINE.

Announcements of Meetings

California Chapter of American College of Chest Physicians Sponsors Meeting

The Interim Session of the American College of Chest Physicians will be held in Los Angeles on December 2, 1951, at the Ambassador Hotel. This meeting will be sponsored by the California Chapter, with Alfred Goldman acting as Scientific Program chairman.

The day-long session will feature discussions by several California physicians, and by visiting physicians from across the country. The dinner will be presided over by Jane Skillen, Olive View, Calif., president of the California chapter. Guest speaker will be Leo Eloesser, United Nations, New York City, Activities of the United Nations International Children's Emergency Fund.

The meeting is scheduled to precede the Interim Session of the American Medical Association which will be held in Los Angeles December 4-7.

The regular meeting of the Clark County Medical Society was held at Zutz Cafe on Tuesday evening, October 2, 1951.

Following dinner and social hour, Dr. Lawrence Noall of Portland, Oregon, gave a scientific paper on "Certain Fractures in Children and Adults."

The regular business meeting followed, with Dr. David Loree presiding. Dr. Asa Seeds, Delegate from Clark County to the Annual Meeting, reported on business matters and actions taken by House of Delegates.

Oregon State Academy of GP Elects Officers

At the annual meeting of the Oregon State Academy of General Practice in Portland, October 10, elections for office for the coming year were held. Verne L. Adams, Eugene, president; Ennis Keizer, North Bend, vice-president; C. E. Mason, Beaverton, delegate; Hugh Stites, Forest Grove, alternate delegate, and Navarre Dunn, Florence, elected to Board of Directors.

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Book Reviews

Books reviewed in the columns of *NORTHWEST MEDICINE* may be borrowed by any subscriber. Write Mrs. Marylyn McCurdy, acting librarian, King County Medical Society Library, Room 121, Cobb Building, Seattle 1, Wash. The library appreciates, but does not demand, reimbursement for postage.

THE PHYSIOLOGICAL BASIS OF MEDICAL PRACTICE, 5th Edition, by Charles Herbert Best, C.B.E., M.A., M.D., D.Sc. (London), F.R.S., F.R.C.P. (Canada), Professor and Head of Department of Physiology, Director of the Banting-Best Department of Medical Research, University of Toronto; and Norman Burke Taylor, V.D., M.D., F.R.S. (Canada), F.R.C.P. (Canada), M.R.C.S. (England), L.R.C.P. (London), F.R.C.S. (Edin.), Professor of History of Medicine and Medical Literature, University of Western Ontario, London, Canada; formerly Professor of Physiology, University of Toronto. 1330 pp. Price \$11.00. The Williams & Wilkins Company, Baltimore, 1950.

Since the first edition, "Best & Taylor" has been a favorite with medical students as a physiology text. Not only does it actively attempt to integrate basic and clinical physiology by its inclusion of apropos clinical conditions, but also it tends to be less dilatory and more conclusive in its coverage of controversial issues. The students still favor it.

This new fifth edition has 1341 pages with 601 figures and three color plates. It is considerably more inclusive than the previous edition and has many new illustrations and a new index. As with previous editions, it is written in rather fine print, two columns to the page.

The text is still almost entirely a two-man project. With rare exception that which was not written by Best was done by Taylor. This organization lends to uniformity of style and perhaps to a more balanced coverage, however, it seems impossible that two men could be the last authorities on thirteen hundred pages of concentrated scientific material.

As a clinician I have had occasion to refer to its pages on various occasions, usually with satisfaction, sometimes with disappointment. For instance, I was unable to find reference to the interesting relationship between BAL, glutathione, and the S-H enzymes, and the link between glutathione and diabetes mellitus.

Such disappointments one meets in searching for specific material in any text. Fortunately in Best & Taylor there is a readable presentation and a practical clinical approach that makes up for such shortcomings, and makes the book a desirable addition to any clinician's library or to a medical student's book shelf.

WILLIAM E. WATTS

PROGRESS IN GYNECOLOGY. Volume II. Edited by Joe V. Meigs, M.D., Clinical Professor of Gynecology, Harvard Medical School; Chief of Staff of Vincent Memorial Hospital, Gynecological Service of Massachusetts General Hospital; Surgeon, Pondville Hospital; Gynecologist, Palmer Memorial Hospital; and Somers H. Sturgis, M.D., Clinical Associate in Gynecology, Harvard Medical School; Assistant Surgeon, Massachusetts General Hospital, Boston, Massachusetts. 821 pp. Price \$9.50. Grune & Stratton, New York, 1950.

In its second volume it is not complete in text in gynecology. In order to obtain the finest information available in certain fields, outstanding investigators, in their own particular line of work, were asked to write a chapter and concise reviews on that certain subject. In this way this text brings to the reader all of the great progress in the various branches of gynecology. This is merely a collection of papers of many medical men, surgeons, gynecologists and endocrinologists. Their work brings the reader immediately up to date, and it is an excellent reference for every field of gynecology.

It is refreshing to find in a text stress laid in the newer developments as well as the correlation of the new with the old. The chapters on functional diseases of the pelvic organs is exceptionally well written, and its practical applications laid out in such a manner that it will be of definite benefit to every practicing physician.

This book is, by no means, meant primarily for gynecologists, as it covers all of the various fields seen so frequently by general practitioners. Almost every branch of gynecology is thoroughly covered, as well as a considerable amount of obstetrics. It is my feeling that any doctor who is unable to keep up with the modern advancements can profitably have this text available at all times.

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1. Towse, R. C., Berberian, D. A., and Dennis, E. W.: *New York State Jour. Med.*, 50:2035, Sept., 1950.
2. Berberian, D. A., Dennis, E. W., and Pipkin, C. A.: *Am. Jour. Trop. Med.*, 30:613, Sept., 1950.

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1. Smith, A. E., and Fischer, C. C.: The Use of Carob Flour in the Treatment of Diarrhea in Infants and Children, *J. Ped.* 35:422 (Oct.) 1949.
2. Kaliski, S. R., and Mitchell, D. D.: Treatment of Diarrhea with Carob Flour, *Texas State J. Med.* 46:675 (Sept.) 1950.

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Animal studies have forcefully demonstrated the adverse effect of inadequate protein nutrition on recovery processes.¹ Protein-depleted rats fed an adequate repletion ration manifest a rapid recovery of lost weight, of normal plasma protein and hemoglobin levels, of certain enzyme systems, and of normal capacity to synthesize antibody protein and to resist infection. On the other hand, reduction in the amount of but one essential amino acid in the repletion ration quickly causes loss of appetite, diminished food consumption, and inadequate weight recovery. This quick appearance of overt symptoms due to a shortage of an essential amino acid contrasts sharply with the delayed appearance of symptoms induced by deficient intake of any other essential nutrient.

These manifestations of acute amino acid deficiency noted in the rat can occur as readily in the normal human subject consuming a diet lacking in any one of the eight essential amino acids.² Loss of appetite and of body nitrogen accompanied by malaise quickly results. Furthermore, addition of the missing amino acid to the diet quickly restores the appetite, nitrogen equilibrium, and the previous state of health. Apparently, even in normal persons, lack of an amino acid in the diet partially or completely interrupts protein synthesis as well as increases tissue protein catabolism.¹ The conclusion is incontestable, therefore, that adequate protein nutrition is vital for speeding the processes of recovery from massive disease or major surgery.

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1. Cannon, P. R.: Recent Advances in Nutrition with Particular Reference to Protein Metabolism, Lawrence, Kansas, University of Kansas Press, 1950, pp. 56-60.

2. Rose, W. C.: The Nutritive Role of the Amino Acids, The Science of Nutrition, New York, The Nutrition Foundation, 1946.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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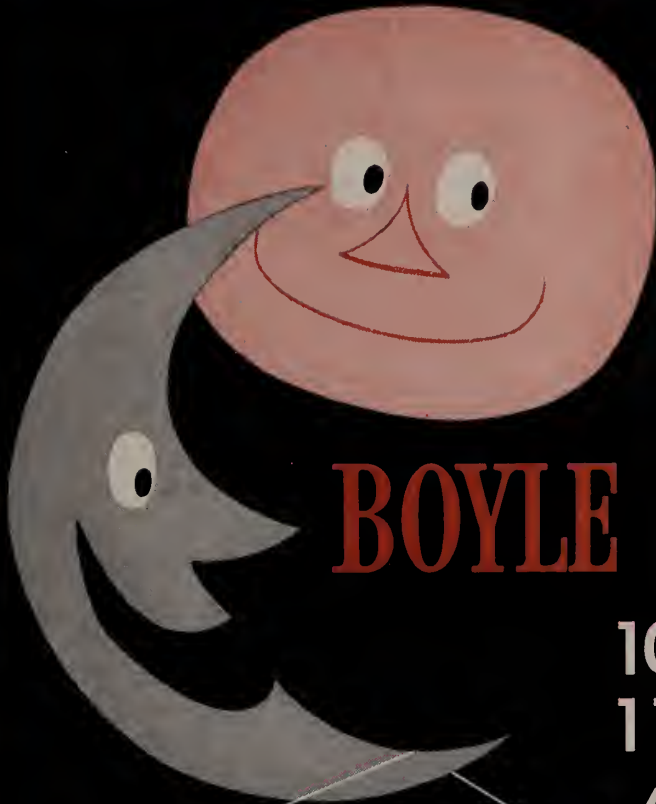
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Hamblen, E. C.: North Carolina M. J. 7:533 (Oct.) 1946.

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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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References:

- 1 Krantz, Kibler and Bell: "The Neutralization of Gastric Acidity with Basic Aluminum Aminoacetate," J. Pharmacol. and Exper. Therap., 82:247 (1944).
- 2 Paul, W. D., and Rhomberg, C.: "Medical Management of Uncomplicated Peptic Ulcer," J. Iowa M. Soc. 35:167-85 (1945).
- 3 Holbert, J. M., Noble, Nancy, and Grote, I. W.: J.A.Ph.A., Scientific Edition, 36:149 (1947).
- 4 Holbert, J. M., Noble, Nancy, and Grote, I.W.: J.A.Ph.A., Scientific Edition, 37:292-294 (1948).

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	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro- intestinal System	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio- vascular System	Rapid heart rate Peripheral vaso- constriction	Slow heart rate Vasodilatation
Functional Manifesta- tions	Palpitation Tachycardia Elevated blood pressure Dry mouth and throat	Heartburn Nausea-vomiting Low blood pressure Colonic spasm

The data here tabulated is from references 3,4,5,6,7, given below.

When the clinical picture is suggestive of functional disorder, the diagnosis is supported by the presence of the following indications of autonomic lability:

Variable Blood Pressure
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Changing pulse rate
Deviations in B. M. R.
Exaggerated Cold Pressure Reflex
Oculo-Cardiac Reflex Abnormalities
Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relieving the somatic disturbance to prepare the patient for psychotherapy*; 2) guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

*Drug treatment using adrenergic and cholinergic blocking agents in conjunction with sedatives, 8,9,10.

1. Ebaugh, F.: Postgrad. Med. 4: 208, 1948. 2. Wilbur, D.: J.A.M.A. 141: 1199, 1949. 3. Williams, E. and Carmichael, C.: J. Nat'l. Med. Assoc. 42: 32, 1950. 4. Goodman, L. and Gilman, A.: The Pharmacological Basis of Therapeutics, The Macmillan Co., 1941. 5. Katz, L. et al.: Ann. Int. Med. 27: 261, 1947. 6. Weiss, E. et al.: Am. J. Psychiat. 107: 264, 1950. 7. Alvarez, W.: Chicago Med. Soc. Bulletin, 581, 1950. 8. Rakoff, A.: A Course in Practical Therapeutics, Williams and Wilkins, 1948. 9. Karnosh, L. and Zucker, E.: A Handbook of Psychiatry. C. V. Mosby Co., 1945. 10. Harris, L.: Canad. M.A.J. 58: 251, 1948.

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MEETINGS OF MEDICAL SOCIETIES

ANNUAL SOCIETY MEETINGS

American Medical Association.....	Chicago, 1952
Clinical Session, Los Angeles, Dec. 4-7, 1951	
Oregon State Medical Society.....	Portland
President, Blair Holcomb	Secretary, R. F. Miller
Portland	Portland
Washington State Medical Association.....	Sept. 13-17, 1952
President R. A. Benson	Secretary, Bruce Zimmerman
Bremerton	Seattle
Idaho State Medical Association.....	Sun Valley—June 15-18, 1952
A. M. Popma	Secretary, R. S. McKean
Boise	Boise
Alaska Territorial Medical Association.....	Anchorage—June, 1952
President, H. Romig	Secretary, W. P. Blanton
Anchorage	Juneau

PERIODICAL SOCIETY MEETINGS

NORTHWEST

North Pacific Society of Neurology and Psychiatry.....	Seattle, 1952
President, S. N. Berens	Secretary, R. A. Coen
Seattle	Portland
North Pacific Pediatric Society	
President, Gordon Matthews	Secretary, S. G. Babson
Vancouver, B. C.	Portland
North Pacific Surgical Assn.....	Vancouver, B. C., Nov. 16-17, 1951
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Tacoma	Seattle

OREGON

Central Willamette Society.....	Second Thursday
President, W. W. Ball	Secretary, F. R. Asbury
Corvallis	Corvallis
Oregon Academy of Ophthalmology and Otolaryngology—Third	
Tuesday, Old Heathman Hotel, Portland	
President, R. S. Fixott	Secretary, G. E. Chamberlain
Portland	Portland
Oregon Pathologists Association, Second Wednesday—Portland	
President, V. D. Sneed	Secretary, J. E. Nohlgren
Portland	Portland
Oregon Radiological Society—Second Wednesday—University	
Club, Portland	
President, Arthur Hunter	Secretary, J. R. Raines
Portland	Portland
Portland Academy of Pediatrics.....	First Monday
President, S. G. Babson	Secretary, Edward Rector
Portland	Portland
Portland Surgical Society.....	Lost Tuesday
President, J. M. Roberts	Secretary, J. W. Nadal
Portland	Portland
Southern Oregon Medical Society.....	Roseburg—May 13, 1952
President, A. M. Johnson	Secretary, F. C. Adams
Roseburg	Klamath Falls

WASHINGTON

Washington State Obstetrical Society.....	1952
President, E. G. Layton	Secretary, L. B. Donaldson
Seattle	Seattle
Puget Sound Academy of Ophthalmology and Otolaryngology	
.....Third Tuesday—Seattle or Tacoma	
President, J. F. Tolan	Secretary, Willard Goff
Seattle	Seattle
Seattle Academy of Surgery.....	Third Friday
President, D. O. Kraabel	Secretary, H. L. Schiess
Seattle	Seattle
Seattle Gynecological Society.....	Third Wednesday
President, Gerald Thomas	Secretary, Hugh Nuckols
Seattle	Seattle
Seattle Pediatric Society.....	Fourth Friday
President, W. A. Jaquette	Secretary, G. E. M. Adkins
Seattle	Seattle
Seattle Psychoanalytic Study Group.....	First Thursday
President, Gert Heilbrunn	Secretary, E. W. Haertig
Seattle	Seattle
Seattle Surgical Society.....	Second Friday
President, J. A. Duncan	Secretary, R. B. Hearne
Seattle	Seattle
Washington State Society of Anesthesiologists.....	Fourth Friday
President, D. C. Moore	Secretary, K. F. Eather
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*Guerriera, W.F.: Texas State Jour. Med., 45:274, May, 1949.

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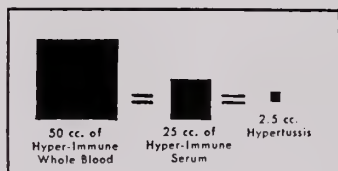
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Vol. 50

DECEMBER, 1951

No. 12

Attention, Please!

Outline of Undesirable Effects of ACTH and Cortisone—Bakke
Voluntary Admissions to State Hospital—Jones and Hughes

Washington State Medical Association Annual Meeting
Proceedings—Page 942

Post-Operative Tonsil Bed Bleeding—Hartzell

A Christmas Pledge—Page 929

Correspondence—Page 976

Contents—See Page 914

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Back in 1876—when Eli Lilly and Company had just begun—
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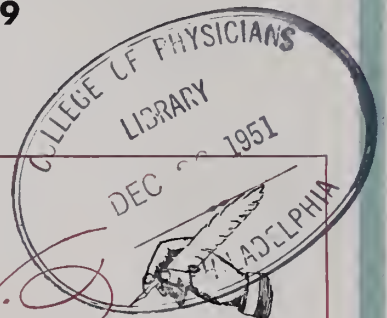
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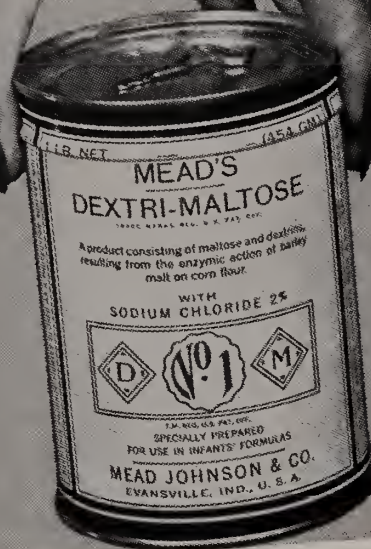
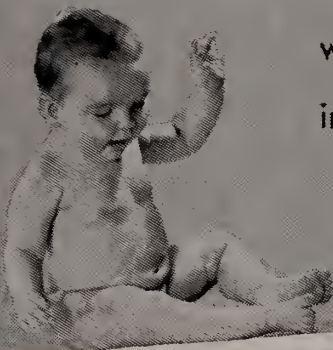
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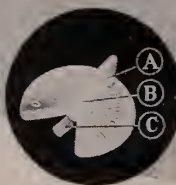
One such report, typifying others soon to be published, is furnished by Nina Ferrera, M.D. (2). His evaluation is based on an extensive clinical use of the Q-Test at the Woman's Hospital, Pasadena, where it was proved 95% to 98% accurate.

That the fallibility of pregnancy diagnosis approaches the optimum zero percentile through the Q-Test is emphasized in all the reports of recent clinical observations.

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(1) American Journal of Obstetrics and Gynecology, March 1941 (2) Ibid., March 1951

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ANDROMACHI

From *Blakiston's New Gould Medical Dictionary*: "Theriaca Andromachi. Venice treacle, a compound containing nearly 70 ingredients . . ." See *NORTHWEST MEDICINE*, 50:708, Sept., 1951.

WASHINGTON STATE TAX BILL GROWS. Washington citizens can take small comfort in a 3 per cent cut in property tax bill from 1950 to 1951. Ten years from 1941 to 1951 saw a jump of 107 per cent. Total of state, county, city and district property levies was \$40,492,516.24 in 1941 and \$83,637,922.46 in 1951.

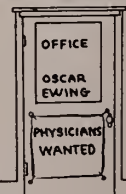


MANY KOREA VETS HOSPITALIZED. Veterans Administration has announced that at the end of September there were 1,056 patients in V.A. hospitals who had been discharged since Korean war started. No statistics on service or non-service connection.

OSCAR PAYS UP. Indiana got a check for \$6,470,117 last month. Federal Security Administrator Ewing had held up that state's share of welfare funds, August through November. He didn't like their attempt to shake out chiselers by publishing names of welfare recipients but the Congress quickly made it legal. Wonder how many dollars in taxes were extracted from Indiana so Oscar could be so magnanimous?

HEADACHE AND INSOMNIA EPIDEMIC? Useful statistics from National Production Authority indicate production of acetylsalicylic acid up 25 per cent and acetanilid up 170 per cent since start of Korean war. Barbituric acid derivatives up 50 per cent. Maybe we have a few more victims of the jitters, too. Thiamin output jumped 35 per cent and pyridoxine an even 100.

OSCAR WANTS MORE PHYSICIANS. In a recent speech before meeting of the American Federation of Labor, Oscar Ewing plumped for federal aid to medical education, said, "... the chronic shortage of doctors is scandalous." Not many weeks ago he was wearing a different colored coat. Seems we remember him doing a little bragging about great increase in longevity since turn of the century. Guess he was just eager for someone to put a wreath on his own shining brow that day. He must have conveniently forgotten the tremendously increased effectiveness of modern physicians. Little things like hard roads, the automobile, penicillin and sulfa drugs aren't in it with the FSA.



THINGS TO COME. National Institute of Health has spent \$89,892 to develop a heart-lung machine so those organs may be bypassed for surgical attack. Gadget should be out next year.

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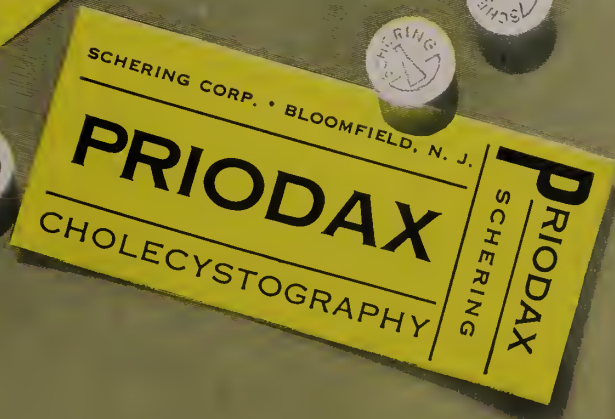
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1. Hansel, F. K.: Allergy of the Nose and Paranasal Sinuses. St. Louis, C. V. Mosby Co., 1936, p. 769.
2. Lands, A. M., Hoppe, J. O., Siegmund, O. H., and Luduena, F. P.: *Jour. Pharmacol. & Exper. Therap.*, 95:45, Jan., 1949.
3. Luduena, F. P., and Ananenkov, E.: *Jour. Allergy*, 20:434, Nov. 1949.

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*Potterfield, T. G., and Starkweather, G. A.:
J. Philadelphia General Hosp. 2:6 (Jan.) 1951*

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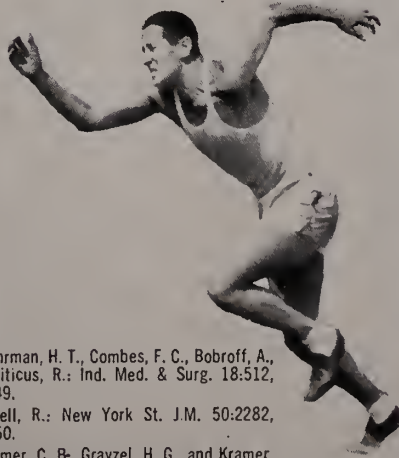
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NORTHWEST MEDICINE

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EDITORIALS

Politics and Voluntary Health Programs

IT IS generally conceded by physicians that initiation and development of the voluntary health service programs such as offered by medical service bureau, Blue Shield plans and countless private insurance carriers, was a powerful force in proving the lack of any necessity for government trying to take over the nation's medical care. That voluntary medical care programs still remain a potent force is attested by none other than Louis H. Bauer, president-elect of the American Medical Association, who as recently as early October, speaking before the District of Columbia Medical Society, expressed the view the medical profession must be brought "100 per cent behind the voluntary health insurance program."

But there is another side, and a dangerous one, to the story of voluntary health programs.

Power-seeking politicians love them too!

Any doubt on that score should be dispelled by a study of Senate Bill 2171 which would "authorize grants to enable the States to survey, co-ordinate, supplement, and strengthen their existing health resources *so that hospital and medical care may be obtained by all persons.*" (Emphasis ours.) This bill is sponsored by Senators Hill and Aiken, and was referred to the Committee on Labor and Public Welfare. It is similar in many respects to S. 1456 of the 81st Congress, which had Senators O'Connor, Withers and Morse as additional sponsors, but includes "refinements" to meet some of the objections disclosed in public hearings held in May 1949.

S. 2171 is temporarily on the shelf, due to adjournment of the 82nd Congress, but when the politicians reassemble in January anything can happen. If enough people know about the tricks in this bill it is unlikely it can be passed in an election year, but one never knows. In any case, it can be studied with profit for, having had its glaring defects exposed through hearings, it now approaches a model of political jokery and gobblydegook associated with "fringe" legislation designed to soothe or ensnare the unwary while the main political goal is sought.

Stated objectives are two: (1) To make federal funds available to states on a formula, varying

from 33⅓ per cent to 75 per cent of state contributions, to be spent by the state on establishing voluntary hospital and medical care programs for *sub-income* persons, with subscriptions based upon ability to pay; (2) to make federal funds available on 50-50 matching basis for the states to survey (a) needs for diagnostic facilities, (b) mental, tuberculosis and chronic disease facilities, (c) areas where there may be a shortage of physicians, (d) enrollment in existing voluntary prepayment plans, and finally, to *finance the cost of making plans to correct the foregoing conditions.* (Emphasis ours.)

To detail all the jokers and trick spots would require more space than is available, so comment on a few of the outstanding ones will have to suffice for the whole. Where emphasis is indicated, it is ours.

States are *required* to submit plans which *conform with certain conditions set forth in the bill*, and are *required* to follow regulations issued by the surgeon-general of the *Federal Security Agency's* Public Health Service which meet with the approval of a *Federal Hospital and Medical Care Council*, to be created by the bill.

This Council, far from being the safeguard it may appear to the gullible, is actually more of a noose-fashioning device. It would be made up of ten members *appointed* by the *Administrator of the Federal Security Agency*. Two appointees shall be doctors of medicine, *two hospital administrators, two voluntary plan administrators, and four to represent consumers.* Thus this Council *could* be loaded eight to two against believers in a free medical profession, or even ten to nothing if certain doctors of medicine were selected.

Interesting feature is the provision that *once the regulations are promulgated* this Council becomes strictly *advisory*.

The bill is reported to include two specific "safeguards" to eliminate the dangers of federal control. The first prohibits the Surgeon General from exercising authority with respect to the selection, tenure of office, or compensation of any individual employed by the state agency. The second prohibits

federal officers or employees from exercising any supervision or control over the administration of any hospital going along with the program, "except as otherwise specifically provided." Many physicians suspect that socialization of medicine may be attempted via hospital channels. Looking at this "assurance" extended to hospitals they may wonder if their fears are not justified.

States denied federal funds by the Surgeon General (an inadvertent admission the boys will not hesitate to use "persuasion?") may appeal to the Hospital and Medical Care Council, which *may* overrule the Surgeon General. *There is no other appeal.*

In spite of the refinement designed to make it more palatable, the bill is unusually brazen in a number of respects, so much so that one wonders if its sponsors delude themselves they are leading from strength, or if its perniciousness was deliberately built in with trading purposes in mind, such as offering to "kill" this bill provided another is accepted in its stead.

S. 2171 will bear watching in its own right as the next session of Congress convenes; it is dangerous legislation not in the public interest. It would hamstring the good now rendered the public through the non-political conduct of the voluntary health programs, and convert them to a tool of the socializers.

Useful Plaque

Good ideas in the field of public relations are usually simple. This applies to the simple but dignified plaque just announced by Chicago office of AMA.

The new plaque is described on page 982. It is attractive and well printed in brown ink on buff paper. The brief message it bears is overprinted on halftone reproduction of the AMA insignia. The printed sheet is mounted on a firm piece of hardboard and covered with solidly bonded clear plastic. Size is slightly narrower and a little longer than a page in *NORTHWEST MEDICINE*. Special support on the back permits standing on a table or hanging as desired.

Idea behind this excellent piece of public relations promotion is actually the personal relationship between physician and patient. It is essential that there be mutual understanding and mutual appre-

ciation between physician and patient. If such exist, the physician has excellent public relations. If the same situation exists across the land, the entire profession has good public relations.

All research in medical public relations has shown one major source of weakness. It is in the mutual understanding between physician and patient. The patient should be free to ask any question he wishes regarding treatment or fees. Actually he almost always is. Usually he fears he is not. This plaque will do much to dispel the fear.

Every physician who is aware of current trends in physician-patient relationships will welcome this help to those relationships in his own practice. It is a first, and extremely important, step in an entirely new approach to medical public relations on the part of AMA. It deserves wide utilization.

Write a Letter to the Editor

The editorial columns of *NORTHWEST MEDICINE* are open to readers everywhere. Write a letter to the editor expressing your views. Perhaps he can editorialize on the subject matter and thus pass your views along to others.

Or, better still, write an editorial of your own. Send it to the editor of *NORTHWEST MEDICINE* with the request that it be published in an early edition.

The editors will not only appreciate your interest, they will be grateful for your assistance and support. Through your co-operation they will be able to edit and publish a better journal. Address your letter or editorial to Editor, *NORTHWEST MEDICINE*, 323 Douglas Bldg., Seattle 1, Wn.

A Christmas Pledge



*They say that once on Christmas Day,
In foreign land and far away,
There came to earth a strange, calm man
Who left much thought—if think we can.*

*We've tried and tried two thousand years,
But yet we fail to dry the tears
Of Him who wept for us on earth,
And died that we might know His worth.*

*We boast of progress and our might,
We run our fact'ries day and night,
We hurry here, we travel there,
But we forget, He left a prayer.*

*He prayed that some day we could find
The way to friendship with our kind,
And never thought that we would try
To send swift death from blinding sky.*

*He stopped the money-changers then,
But still we deal with greedy men
Who thirst for power and control,
And reckon not with God or soul.*

*We have not met His great desire,
That we should crawl from this deep mire,
Emerging to the clean, strong land,
Which He could see and understand.*

*But we who treat the sick and lame,
Most keenly feel the awful shame
Of morals gone and truth defiled,
And fear that grips each growing child.*

*Thus we who feel and we who see,
Must do our part to keep men free,
And cannot longer stand aside,
For we have strength to turn the tide,*

*So on this Christmas let us take
A pledge that we shall once more make
A nation honest and sincere,
With morals high and without fear.*

ORIGINAL ARTICLES

Outline of Undesirable Effects of ACTH and Cortisone*

JOHN L. BAKKE, M.D.†

SEATTLE, WASH.

IN VIEW of anticipated widespread use of ACTH and cortisone it seems timely to summarize present information concerning their undesirable effects.

Undesired effects of other drugs are usually called side effects. However, this term is not appropriate for ACTH and cortisone because their undesired actions are, in most instances, part of their known physiologic effects. In fact, one might argue that the disease-suppressing effects of ACTH and cortisone are actually side effects. To avoid ambiguity, the designation *undesirable effects* will be used.

Undesirable effects may be classified in several ways but an outline by system review is chosen here. Reported incidence of an undesirable effect is stated in per cent and reference cited. The bibliography is not exhaustive; when an article summarizes several others, only the first is used.

Although undesirable effects are dependent upon dose and especially duration of treatment, the reported series agree that about half of all patients on full doses (100 or more mg. per day) develop complications. Hench noted undesired reactions in 61 per cent,¹ Margolis, 50 per cent;² Kuzell, 65 per cent;³ Boland, 40 per cent;⁴ Thayer, 65 per cent;⁵ Ward, 54 per cent (oral cortisone).⁶ This incidence may be reduced by reduction in dosage or duration of treatment.^{7,8,9,10} However, this frequently defeats the aims of therapy.

It is to be remembered that this outline is limited

to undesirable effects — omitting many striking changes not demonstrated to be harmful.

I. UNDESIRABLE NERVOUS AND PSYCHIC EFFECTS

1. Insomnia, 30 per cent.¹¹
2. Depression reported in as high as 35 per cent.¹² Suicide may result.^{13, 14}
3. Euphoria, including expansiveness, impaired judgment, increased psychomotor activity and hypomania, 18 per cent,¹¹ 9 per cent,¹⁵ 30 per cent,^{5, 16} 29 per cent.⁶
4. Tremors, 16 per cent.¹⁷
5. Psychoses, 1-6 per cent.^{15, 16, 18, 19, 20, 21, 22, 23, 24} One-third have pre-treatment personality disorder.

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* Reviewed in Veterans Administration and published with approval of Chief Medical Director. Statements and conclusions published by the author are the result of his own study and do not necessarily reflect opinion or policy of the Veterans Administration.

† From Medical Service, Veterans Administration Hospital, Seattle, Wash., and Department of Medicine, University of Washington School of Medicine, Seattle, Wash.

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Paranoia tends to predominate. May not appear until drug stopped. May result from as little as 200 mg. cortisone.²⁴

6. Abnormal EEG produced or intensified, 85 per cent.²⁵ Some cases due to hypokalemia.^{26,27}

7. Drowsiness.²⁸

8. Brain damage reported clinically²⁷ and at autopsy.²⁹ Animal experiments verify hypothalamic and thalamic injury by ACTH and cortisone.³⁰

9. Convulsions about 2 per cent, 11 reports.^{11,18,27,31,32} May be fatal.³³ Usually preceded by marked weight gain.¹¹

10. Delirium tremens precipitated 10th day of treatment.³⁴

11. Neuritis among most troublesome of complications in some series.¹⁵ Manifested by paresis and paralyses, 1.4 per cent.^{1,6,11}

12. Cerebro-vascular accident. Related to thrombotic tendency.¹⁵

13. Anosmia.¹⁵ Olfactory hallucinations.⁵

14. Headaches, particularly migraine 2.8 per cent.¹¹

15. Gustatory aberrations.⁵

16. Polyphagia may be troublesome,¹¹ 3 per cent.⁶

17. Coma, unexplained.^{35,36}

18. Tinnitus.¹

19. Transitory deafness.³

II. UNDESIRABLE PITUITARY EFFECTS

1. High blood level of steroids depresses normal pituitary release of ACTH, causes damming back with hyalinization of pituitary basophiles (Crooke

cell changes) and formation of basophile adenomata as seen in Cushing's disease.^{37,38} These changes may lead to pituitary-adrenal failure with the same symptoms noted under III 2 below when treatment is stopped.⁵

2. Growth hormone effects on growth apparently neutralized.^{39,40,41}

3. Thyrotropic and gonadotropic hormones are depressed causing thyroid and gonad hypofunction.⁴²

III. UNDESIRABLE ADRENAL EFFECTS

1. ACTH may exhaust adrenals⁴³ or increase danger of hemorrhagic necrosis⁴⁴ (like Waterhouse Friderichsen's Syndrome) in situations where bleeding tendency is combined with severe stress such as overwhelming sepsis, burns and toxemia of pregnancy.⁴⁵ Cortisone will prevent this hemorrhagic necrosis in experimental situations.⁴⁶

2. Cortisone produces adrenal atrophy^{47,48} associated adrenal failure, masked until cortisone stopped. Then manifested by: (a) Weakness, fatigue, hypotension, arthralgia, nausea, 9 per cent.⁵ (b) Urinary 17 ketosteroid excretion fall to Addisonian levels.⁴⁸ (c) Thorn ACTH-eosinopenia test becomes unresponsive for two to five days.⁴⁹ (d) Diminished response, urinary 17 ketosteroids to 50 mg. ACTH daily.⁴⁹ (e) Excessive sodium and water diuresis, amounting to three times that retained during therapy.⁵⁰ (f) Sudden crises may occur; for example, dramatic respiratory distress.⁵¹ Addisonian crisis reported.¹⁰ (g) Severe relapse of disease being

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treated may occur so that patient is worse than before treatment.^{52,53}

IV. UNDESIRABLE THYROID EFFECTS

1. Corticogenic hypothyroidism claimed to occur, 80 per cent all patients receiving ACTH or cortisone over period of several weeks. Thyroid, 30 mg. per day recommended routinely.⁵⁴ (Others doubt this.) The evidence: (a) Serum protein bound iodine falls.⁵⁵ Others disagree.⁵⁶ (b) I-131 uptake lowered to myxedema range.⁵⁷ (c) Thyroid treatment may improve clinical response to ACTH and cortisone.^{13,58} (d) In one series, 4 of 16 patients treated over one month required exogenous thyroid.⁵⁹

2. BMR elevated by cortisone, of little value in diagnosis of corticogenic hypothyroidism.⁵⁴

3. ACTH and cortisone fail to help hyperthyroidism or exophthalmos, may precipitate exophthalmos.⁶⁰

4. Thyrotoxicosis not previously present may be precipitated after stopping therapy,^{61,62} goiters may enlarge.

V. UNDESIRABLE GONADAL EFFECTS

1. Sex hormone effect of cortisone may lower pituitary gonadotropins leading to loss of libido in male.^{18,63}

2. Testicular atrophy may be expected from animal experiments^{38,64} but not seen clinically.

3. Amenorrhea and other menstrual abnormalities in about 6 to 7 per cent,^{11,15} 2 per cent.^{2,6}

4. Hot flushes, 4 per cent.⁶

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64. Baker, B. L., Schairer, M. A., Ingle, D. J. and Choh Hao Li: Induction of Involution in Male Reproductive System by Treatment with Adrenocorticotropin. *Anatomical Record*, 106:345-359, March, 1950.

5. Virilism in female children.⁶⁵

6. See VII below.

VI. UNDESIRABLE PANCREATIC EFFECTS

1. Steroid diabetes results in 10 to 20 per cent, depending upon dosage.^{2,11,15}

2. Pre-existing diabetes uniformly more difficult to control. Urinary glycosuria may exceed total carbohydrate intake.⁶⁶

3. Insulin resistance striking. Treat with HN₂.⁶⁷

4. Renal threshold lowered causing renal glycosuria.^{68,69}

5. Carbohydrate metabolism abnormal for a month after stopping therapy.⁷⁰

6. Pancreas overload may lead to permanent diabetes as in "Young" dog. Possibility denied by most reviewers—Thorn,⁷¹ Sprague,¹⁸ Engle;⁷² however, we have two instances, one fatal.⁷³ More recently 2 of 18 steroid diabetes cases reported in series of 128 arthritics have shown persistent diabetes after therapy stopped.¹⁵

7. Rat experiments confirm.^{74,75}

8. Review.⁷¹

VII. UNDESIRABLE SKIN EFFECTS

1. Incidence 16 per cent.¹⁵ Review.⁷⁶

2. Acne, frequently cystic, may leave permanent scarring, 17 per cent of 211 cases,¹¹ 15 per cent,²² 15 per cent,⁵ 12 per cent.²

3. Hirsutism, frequently permanent; 8.5 per cent,¹¹ 7 per cent,²² 5 per cent,⁶ 4 per cent.²

4. Loss of head hair.^{2,5,19} Permanent recession of scalp line in a female patient.⁷⁷ Cortisone oint-

65. Rosenberg, I. N. et al.: Clinical Evaluation of Corticotropin Therapy. *A.M.A. Arch. Int. Med.*, 88:226, Aug., 1951.

66. Fajans, S. Louis, L. and Conn, J. W.: Metabolic Effects of ACTH upon Pre-existing Diabetes Mellitus. *J. Clin. Endocrinol.*, 11:455-464, May, 1951.

67. Geller, William, LaDue, J. S. and Glass, G. B. J.: Insuline-Resistant Diabetes Precipitated by Cortisone and Reversed by Nitrogen Mustard. *A.M.A. Arch. Int. Med.*, 87:124-127, Jan., 1951.

68. Kass, E. H. et al.: Renal Glycosuria Induced by Adrenocorticotrophic Hormone. *Proc. Soc. Exper. Biol. & Med.*, 73:669-672, April, 1950.

69. Dustan, H., Corcoran, A. C., Taylor, R. D. and Page, I. H.: Cortisone and ACTH in Essential Hypertension: Establishment of Renal Glycosuria. *Arch. Int. Med.*, 87:627-635, May, 1951.

70. De Venanzi, F.: Effect of ACTH on Decreased Serum Inorganic Phosphorus Induced by Insulin and Glucose. *Proc. Soc. Exper. Biol. & Med.*, 76:770-773, April, 1951.

71. Thorn, George W. et al.: Medical Progress; Clinical Usefulness of ACTH and Cortisone. *New England J. Med.*, 242:783-793, May 18, 1950.

72. Engle, F. L.: Role of Adrenal Cortex in Intermediary Metabolism. *Amer. J. Med.*, 10:556-565, May, 1951.

73. Personal observation.

74. Ingle, D. J., Prestrud, M. C. and Choh H. Li: Effects of Administering Adrenocorticotrophic Hormone by Continuous Injection to Normal Rats. *Amer. J. Physiol.*, 166:165-170, July 1, 1951.

75. Ingle, D. J., Prestrud, M. C. and Nezamis, J. E.: Effects of Administering Large Doses of Cortisone Acetate to Normal Rats. *Amer. J. Physiol.*, 166:171-175, July 1, 1951.

76. Behrman, H. T. and Goodman, J. J.: Skin Complications of Cortisone and ACTH. *J.A.M.A.*, 144:218-221, Sept. 16, 1950.

77. Stoerk, H. C. and Porter, C. C.: Prevention of Loss of Body Fat by Cortisone. *Proc. Soc. Exper. Biol. and Med.*, 74:65-67, May, 1950.

ment locally impairs hair follicles⁷⁸ but could not impair regrowth of forearm hair or beard.⁷³

5. Estrogens, originally claimed to prevent these androgenic effects,⁷⁹ probably do not.⁵

6. Furunculosis, 11 per cent.¹⁷

7. Flushing, especially menopausal hot flushes.¹¹

8. Sweating, 5.7 per cent,¹¹ 11 per cent.⁶

9. Easy bruising.¹¹

10. Purpura 5 per cent.⁴

11. Pigmentation changes 2.4 per cent,¹¹ 5 per cent,³⁵ 32 per cent.² (a) Generalized darkening of skin.⁵ (b) Spots on dorsum of hands.⁸⁰ (c) Pigment bands in nails.³⁹ (d) Pigmentation of scars, nipples, axillae. (e) Not due to melanophore hormone contamination ACTH⁶² since cortisone will also cause pigmentation.

12. Keratosis pilaris⁶³ (due to vitamin A deficiency).⁸¹

13. Striae from weakening subcuticular tissue,⁶³ 3 per cent.⁶

78. Baker, B. L. and Whitaker, W. L.: Growth Inhibition in the Skin Following Direct Application of Adrenal Cortical Preparations. *Anat. Record*, 102:333, 1948.

79. Hench, P. S.: Effects of Cortisone in Rheumatic Diseases. *Lancet*, 2:483-484, Oct. 21, 1950.

80. Videbaek, A. A., et al.: Effect of ACTH and Cortisone on Rheumatic Fever. *Acta Endocrinol.*, 4:245-264, 1950.

81. Mote, J. R., Editor: Proceedings of Second Clinical ACTH Conference, Blakiston, 1951, Vol. I; Klopp, C. T., et al.: Factors Which Influence the Concentration of Serum Vitamin A. Chap. 34, p. 341.

14. Impaired wound healing review,^{82,83} (a) Mechanism includes negative nitrogen balance and impaired fibroblasts.⁸⁴ (b) Biopsy incisions failed to heal 20 per cent.^{5,11} (c) Decubitus ulcers may appear.⁸⁵ (d) Vitamin C deficiency may precipitate scurvy with hemorrhages^{86,87} and impaired healing. (e) Skin grafts fail although slough may be delayed.^{13,88}

15. Psoriasis uniformly worse after therapy.¹³

16. Abscesses and impetigo may follow injection of either ACTH or cortisone.⁵

82. Alrich, E. M., Carter, J. P. and Lehman, E. P.: Effect of ACTH and Cortisone on Wound Healing. *Annals of Surgery*, 133:783-789, June, 1951.

83. Spain, D. M., Molomut, N. and Haber, A.: Biological Studies on Cortisone in Mice. *Science*, 112:335-337, Sept. 22, 1950.

84. Baker, B. L. and Whitaker, W. L.: Interference with Wound Healing by Local Action of Adrenocortical Steroids. *Endocrinol.*, 46:544-551, June, 1950.

85. Barrow, J. F. and Sikes, C. R.: Decubitus Ulcer in Rheumatic Fever Treated with Cortisone. *J.A.M.A.*, p. 41-42, Sept. 1, 1951.

86. Stefanine, M. and Rosenthal, M.: Hemorrhagic Diathesis with Ascorbic Acid Deficiency During Administration of Anterior Pituitary Corticotrophic Hormone (ACTH). *Proc. Soc. Exper. Biol. Med.*, 75:806-808, Dec., 1950.

87. Mote, J. R., Editor: Proceedings of Second Clinical ACTH Conference, Blakiston, 1951, Vol. I; Rosenthal, M. C.: Comment, p. 367.

88. Mote, J. R., Editor: Proceedings of Second Clinical ACTH Conference, Blakiston, 1951, Vol. II; Edwards, B. F.: ACTH in Treatment of Unsuccessful Skin Graft. p. 332.

(To Be Continued)

Washington Experience with Voluntary Admissions to a State Hospital for Observation and for Treatment*

CHARLES H. JONES, M.D.,† and LOWELL R. HUGHES, M.D.‡
SEDRO WOOLLEY, WASH.

FIRST legal recognition of mental hospitals of this state as regional treatment centers for uncommitted patients with acute psychoses was granted two years ago. This occurred with passage of Chapter 198, Laws of Washington 1949, authorizing voluntary admissions for treatment. State mental hospitals, however, had been functioning in this capacity to a marked degree for some time under provisions of Chapter 77, Laws of Washington 1931, which allows the voluntary admission of a resident of the state for observation as to his mental condition. In actual practice patients admitted voluntarily under Chapter 77, Laws of 1931, have for many years received treatment in addition to observation.

STATISTICAL ANALYSIS

Purpose of this paper is to analyze 192 voluntary

admissions to Northern State Hospital from October 1, 1948, to September 30, 1950. This is the biennial period for mental hospital reports to the Governor of the State of Washington as required by law. Also, some brief comments will be made on advantages and limitations of the voluntary method of admission.

Chapter 198, Laws of 1949, did not become effective until June 9, 1949. Therefore, the first 58 patients in this group were admitted under authority of Chapter 77, Laws of 1931, and the last 134 were admitted under provisions of either act depending upon whether the primary purpose of admission was for observation or for treatment.

Counties of residence were as follows: Whatcom, 69; Skagit, 40; Snohomish, 38; King, 30; Kitsap, 5; Island, 3; San Juan, 3; and Pierce, Okanogan, Pacific, Yakima and Chelan one each.

Marital status was recorded as: married, 110; single, 48; divorced, 16; widowed, 13; and separated, 4.

* Read at the 11th Annual Meeting of the North Pacific Society of Neurology and Psychiatry, Victoria, B. C., April 20 and 21, 1951.

† Superintendent, Northern State Hospital, Sedro Woolley, Washington.

‡ Assistant Superintendent, Northern State Hospital, Sedro Woolley, Washington.

Ages of the patients were analyzed according to ten-year groups. The 30-39 year group had the greatest number with 50 and was followed by the 50-59 year group with 42; 40-49 with 35; 20-29 with 33; 10-19 with 18. There were only 15 in the group aged 60 and older.

Diagnostic breakdown is seen in Table 1 with 127 cases regarded as psychotic and 65 cases demonstrating no psychosis.

TABLE 1
PSYCHOSES

Schizophrenia		
Paranoid Type	16	
Catatonic Type	9	
Simple Type	7	
Hebephrenic Type	5	
Unclassified	4	
Total	41	41
Manic Depressive Psychosis		
Depressed Type	19	
Manic Type	7	
Mixed Type	2	
Total	28	28
Involuntal Psychosis		
Melancholia	20	
Paranoid Type	5	
Total	25	25
Psychosis due to Alcohol	8	
Psychosis with Cerebral Arteriosclerosis	7	
Psychosis due to Syphilis of the		
Central Nervous System	6	
Psychosis with Other Somatic Disease	4	
Psychosis due to Convulsive Disorder	2	
Psychosis with Psychopathic Personality	2	
Senile Psychosis	1	
Psychosis with Intracranial Neoplasm	1	
Psychosis with Multiple Sclerosis	1	
Psychosis with Mental Deficiency	1	
Total	127	
WITHOUT PSYCHOSES		
Psychoneurosis	39	
Psychopathic Personality	7	
Alcoholism	6	
Convulsive Disorder	3	
Drug Addiction	3	
Mental Deficiency	2	
Primary Behavior Disorder	1	
Unclassified	4	
Total	65	

Sufficient time has elapsed to allow all except two of the 192 patients to be discharged from a voluntary status. Length of time in the hospital has varied as follows: 28 were discharged within the first month with an average hospitalization of 17 days; 65 were discharged between one and two months; 58 between two and three months; 15 between three and four months; 5 between four and five months; 5 between five and six months; 7 between six and seven months; 3 between seven and eight months; 1 between eight and nine months; and 3 between eleven and twelve months. Thus it is seen that 176, or 91 per cent of the patients admitted on a voluntary basis, were released within six months. Nine patients were dis-

charged for the purpose of obtaining regular court commitments. Four patients died while in the hospital on a voluntary status.

DISCUSSION

Until 1931 all admissions to state mental hospitals were governed by action of the judges of the various superior courts of the state. Chapter 77, Laws of 1931, however, allows any citizen to apply to the superintendent of a state hospital for admission for observation as to his mental condition. It further provides that upon the receipt of such application it is the duty of the superintendent to cause the person to be examined by the medical staff as to his mental status. If examination shows the applicant to be in such mental condition as to warrant observation for the purpose of determining whether he is or is liable to become insane, authority for admission can be granted by the Director of the Department of Public Institutions. The law requires a report to be sent to the superior court of the county of the voluntarily admitted person's residence if a psychosis is disclosed during the observation period. Examination of Table 2 shows that there has been a gradually increasing number of persons admitted voluntarily over the past 20 years.

TABLE 2*

	Western State Hospital	Eastern State Hospital	Northern State Hospital
1931	...	...	...
1932	...	...	16
1933	...	3	31
1934	41	1	48
1935	72	8	40
1936	71	18	49
1937	51	13	51
1938	49	21	46
1939	41	20	78
1940	39	17	40
1941	53	21	41
1942	50	19	45
1943	10	20	33
1944	19	16	53
1945	27	21	41
1946	42	10	108
1947	36	5	62
1948	59	5	86
1949	94	39	115
	754	257	983

* From maintenance files of the Department of Public Institutions.

It appears, therefore, that Section 19, Chapter 198, Laws of Washington 1949, merely legalizes a condition which has existed for many years. Nevertheless, the law does clarify certain principles to be followed in admitting patients voluntarily for treatment. Section 19 provides that any state hospital shall receive and detain as patient any person who is, in the opinion of the superintendent, suitable for hospital care and treatment, upon receipt of a written application and in accordance with certain statutory requirements. In case of an adult person the application must be made voluntarily at a time when he is in such condition of mind as to render

him aware of the significance of his act. Minors may be admitted if the application is made by parents, guardians, or other persons entitled to the minors' custody.

Within the act the superintendent is given discretionary responsibility of determining the types of cases which can be benefited by treatment and returned to normal life and mental condition. Such benefit must be probable, in his opinion, within a period of six months. This has been construed to mean that patients with acute treatable psychoses who otherwise could be committed by regular court procedures or who might be deprived of early treatment because of fears of being determined legally insane are eligible for admission.

In addition, Section 19 provides that no adult person received voluntarily by a state hospital shall be detained for more than 12 days after he gives notice in writing of desire to leave. Likewise, no minor can be detained for more than 12 days after notice has been given by his parent or guardian. However, if it is evident that further care, treatment, or restraint is necessary, proceedings for a regular court commitment must be started. No person may be carried as a voluntary patient for more than one year. Also, the law states that no person shall be admitted voluntarily unless he has been a resident of the State of Washington for a two-year period.

The concept of voluntary admissions to state psychiatric hospitals for treatment has met with a most popular acceptance. Prospective patients have been referred to our hospital by physicians, law enforcement officials, social workers, welfare agencies, discharged patients and a variety of interested and well meaning laymen. The major problem raised has been one of screening applicants for admission.

It is our opinion that it was neither the intent of the recent act to change the primary function of the hospital, which is to give care and treatment to the committed mentally ill, nor was it the intent of the act to squander resources of public institutions unnecessarily on obviously untreatable cases. On the basis of trial and error and on the basis of other laws excluding certain psychiatric categories from the state mental hospitals, criteria for admission have been developed. The definite criteria for suitability of admission have been outlined and given to all members of the hospital staff. This information has been given point by point to all persons inquiring as to existing conditions under which the prospective patient may be admitted.

The criteria are as follows:

1. Demonstration of a mental disorder for which a person would normally be committable by court within the liberal interpretations of the commitment laws given by most superior court judges and for which effective treatment is available at our hospital.

2. Applicant must have been a resident of the State of Washington for two years.
3. Applicant must show a condition of mind in which he is fully aware of the significance of signing a request for admission.
4. Advance payment of customary maintenance charge of \$40.60 per month is required. Responsibility for future payments of the same amount monthly in advance must be assumed by a reliable person.

Specifically ineligible for voluntary admission are the following:

1. Patients unable to benefit from treatment within a six-month period including those suffering from chronic, mental unsoundness or from any of the psychoses commonly associated with advancing age.
2. Mental defectives.
3. Alcoholics.
4. Drug addicts.
5. Persons under charges unless, however, a court order is presented releasing the person for the purpose of making application for voluntary admission.

It has been possible to avoid numerous useless and unwarranted trips to the hospital by clearly explaining all of the above criteria to every person making an inquiry from a distance. However, early in the biennium, in spite of all precautions, many persons obviously not acceptable presented themselves at the hospital for admission. On some occasions we have been extremely embarrassed to have ambulances deliver for voluntary admission elderly patients who were suffering from chronic, neurologic or medical disorders of many years' standing. Those patients offered no diagnostic challenge. No hopeful treatment program was feasible. It has been embarrassing, both for the hospital and for the referring physician, public official or other person, when we have been unable to admit such invalids lawfully. In such cases with concomitant mental symptoms regular court commitments are indicated.

In spite of awkward situations which sometimes develop, the voluntary method of admission is proving to be of value. We are certain that it does bring many patients to the hospital sooner than they might otherwise come. Also, the concept of voluntary admission has helped point out that the mission of Northern State Hospital is not to care for patients with chronic, medical diseases but is to give care and treatment to the mentally ill.

It may be noted that some of the diagnoses in Table 1 are of conditions not eligible for admission. These were admitted inadvertently as essential information was not available or was withheld at the time of admission examination. However, with the increase in our medical staff during the past year it has become possible to give applicants a more searching evaluation than before.

CONCLUSIONS

In conclusion it might be stated that the mental hospitals of the State of Washington do not have the facilities or professional personnel to assume

added responsibilities or to compete with private physicians or institutions. During the period covered by this report we feel that the voluntary method of admission has been utilized in a manner within the traditional role of public psychiatric institutions, namely, to supplement the private practice of medicine.

The task of providing care for persons acutely disabled or suffering chronically from mental illnesses has been delegated for many decades to state

mental hospitals. As a result, treatment programs have been developed which are particularly efficacious in certain cases. There should be no question that care in a state mental hospital is the treatment of choice for many psychiatric patients acutely ill who do not have substantial financial resources. The voluntary method of admission is one which may be used effectively without impairing the patient's dignity appreciably or causing him to lose his civil rights.

Simple Procedure to Reduce Post-Operative Tonsil Bed Bleeding

MILTON K. HARTZELL, M.D.

EUGENE, OREGON

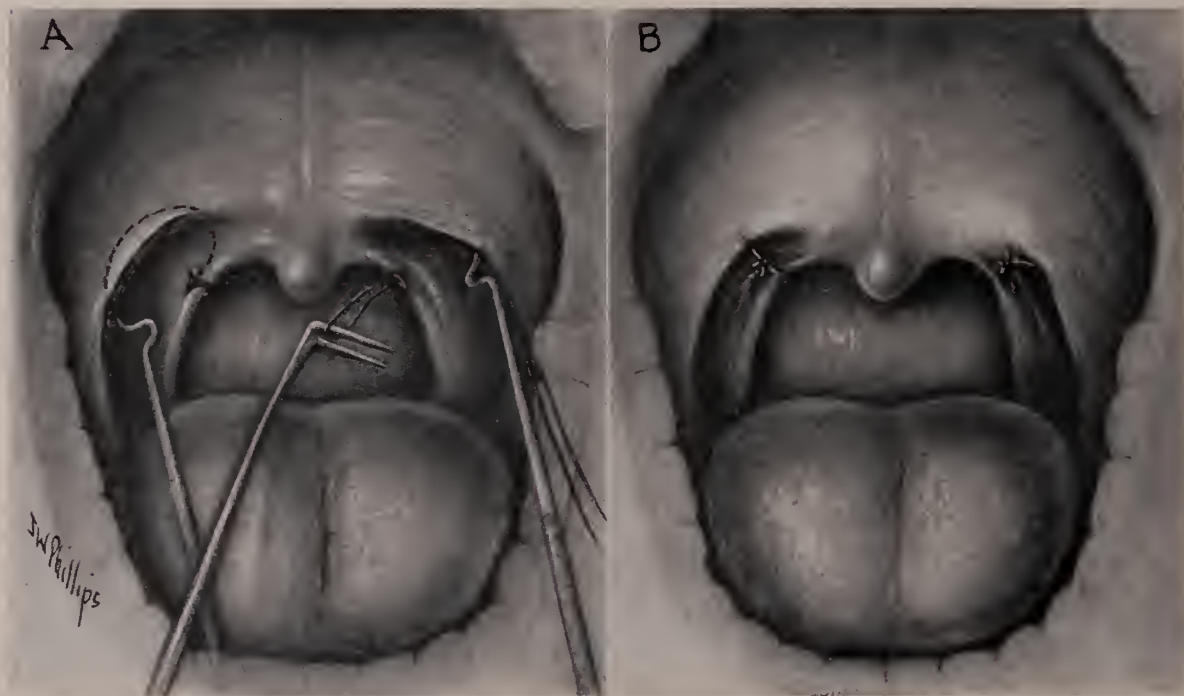


Fig. 1. A—Right, course of Dupuy-Weiss needle. Left, use of Boettcher tonsil hook. B—Sutures tied.

WITH forebearance of the older specialists, I would like to present a short article on simple technic to prevent many post-operative tonsil bleeders.

I will not go into pro and con arguments of bleeding time, coagulation time, vitamin C, vitamin K, calcium, pre- and post-operative drugs, but limit my subject to technic and simple procedures.

I use only the dissection and snare method in tonsillectomy. After the inverted U incision through the mucosa, I use the Colver tonsil dissector to free the peritonsillar tissue away from the capsule. Tissues are pushed away from the tonsil in the same manner as one would peel the skin from an orange. After dissecting down to the pedicle (including the plica triangularis which many times contains small lymphoid patches) the snare is applied and slowly drawn up, keeping the point to-

ward the base of the pedicle. Slowly increased pressure snares the tonsil off cleanly.

Using the Dupuy-Weiss (right and left) tonsil needles, the fossae is sutured. The right needle is used with a 00 plain catgut and enters the anterior pillar about midway. It is carried upward and medially comes out midway on the posterior pillar or at base of uvula. It catches successively the glosso-palatinus muscle fibers, the loose peritonsillar tissue and the pharyngo-palatinus muscle fibers. Course of the needle runs just under the surface of fossal structures. A Boettcher tonsil hook is very useful in reaching the suture to pull the short end through. A surgeon's knot is made. The opposite side is done and the patient returned to the ward.

The usual 4-8 per cent incidence of post-operative hemorrhage is considerably reduced when using this simple technic.

An Advertisement of G. D. Searle & Co.

(The Council on Pharmacy and Chemistry of the American Medical Association has adopted the following statement of Actions and Uses and of Dosage for publication in connection with a description of Banthine Bromide for inclusion in New and Nonofficial Remedies)

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Actions and Uses.—Methantheline bromide, a parasympatholytic agent, produces both the peripheral action of anticholinergic drugs such as atropine and the ganglionic blocking action of drugs such as tetraethylammonium chloride. Tolerated amounts of methantheline bromide exert side effects typical of atropine-like drugs, but cause less tachycardia, and also less postural hypotension than does tetraethylammonium chloride. Toxic doses produce a curare-like action at the somatic neuromuscular junction.

Clinical studies indicate that the drug effectively inhibits motility of the gastrointestinal and genitourinary tracts and, to a variable degree, diminishes the volume of perspiration and salivary, gastric and pancreatic secretions. It also decreases mucoprotein secretion. Like atropine, it produces mydriasis and cycloplegia when applied locally to the eye or administered systemically, but until more clinical evidence becomes available, its local use for this purpose is not recommended. The value of the drug for preventing abnormal cardiac reflexes through the vagus during thoracic surgery, or as an agent for routine preoperative medication in place of atropine, requires further investigation before final conclusions can be reached.

Methantheline bromide is indicated for clinical use whenever anticholinergic spasmolytic action is desired, provided it is not contraindicated because of its atropine-like characteristics or because of a patient's intolerance to the unavoidable side effects of such therapy. It is useful as an adjunct in the management of peptic ulcer, chronic hypertrophic gastritis, certain less specific forms of gastritis, pylorospasm, hyperemesis gravidarum, biliary dyskinesia, acute and chronic pancreatitis, hypermotility of the small intestine not associated with organic change, ileostomies, spastic colon (mucous colitis, irritable bowel), diverticulitis, ureteral and urinary bladder spasm, hyperhidrosis or control of normal sweating which aggravates certain dermatoses, and control of salivation.

Methantheline bromide produces some degree of cycloplegia and mydriasis in therapeutic doses and

therefore should not be administered to patients with glaucoma. It sometimes decreases the ability to read fine print. Xerostomia (dryness of the mouth) is a common, sometimes transient, side effect. Urinary retention of varying degree may occur in elderly male patients with prostatic hypertrophy, and some patients may have difficulty emptying the rectum. Patients with edematous duodenal ulceration may experience nausea and vomiting during initial administration of the drug. These patients should take only liquids during the institution of drug therapy. All patients should be advised of the possible occurrence of side effects. Overdosage sufficient to produce a curare-like action may be counteracted by prompt subcutaneous injection of 2 mg. of neostigmine methylsulfate.

Dosage.—Methantheline bromide is administered orally or parenterally by either the intramuscular or intravenous route. Parenteral administration is not advised for patients able to take the drug orally. The average initial adult dose, oral or parenteral, is 50 mg. For patients with considerable intolerance, 25 mg. may be employed. In the management of peptic ulcer, a beginning schedule of 50 mg. three times daily before meals and 100 to 150 mg. on retiring is suggested. However, the usual effective dose is 100 mg. four times daily, although some patients may require more or less than this amount. The dosage may be increased to tolerance, using dryness of the mouth as a guide, and adjusted to meet the individual response of patients. Maintenance dosage in peptic ulcer is usually considered to be about one-half the therapeutic level. In the management of other hypermotile or hypersecretory states, the dosage should be adjusted to the smallest amount which will relieve the symptoms. When spastic conditions are secondary to inflammatory or other organic lesions, therapy directed toward the cause should be employed whenever possible.

G. D. SEARLE & CO.

Tablets Banthine Bromide: 50 mg.

Ampuls Banthine Bromide: 50 mg.

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Opinions, views or comments presented in articles appearing in this section are those of the individual authors and are not necessarily those of Oregon State Medical Society.

Fellow Passengers

Doctors, as well as other citizens, have had a number of occasions when they could shake their heads in some bewilderment at the manner in which the newspaper segment of what "fourth estaters" call The Press conducts its news affairs. No newspaper of which the writer is aware is immune to the process of not being able to please all of its customers all of the time, but some seem more adept than others at getting their editorial and news policies unsynchronized.

Your correspondent enjoyed a few smiles as the Salem Statesman was taken to task in another section of this publication for its editorial shortcomings and wriggled under the educational process. But an outright chuckle was delayed until a few days later when he chanced to observe a performance in contrasts in the sedate and stately *Oregonian*.

Dramatically headed across multiple columns of the front page was the news story of the president's clamp-down on all government sources of information, on the alleged grounds that "secret" information was being given the enemy through failure of the press to handle such matters properly. Then on its editorial page, in a leaded full column of concern, the *Oregonian* was aghast at this "brazen attack on the freedom of the press." The substance of the editorial seemed sound, the conclusion logical, and

your correspondent mildly rejoiced that the paper had seen fit to swing a vigorous cudgel in defence of freedom, press segment. For, he reasoned, an experience of this sort might be good for the editorial thought processes, might possibly make it easier for editors generally to recognize the essential linkage between freedom of medicine and freedom of the press, a point which the writer had stressed in exchanging health pleasantries over the recent years with a number of illustrious custodians of the editorial pen.

The rejoicing proved short-lived, thanks to a short three-inch news report of a talk given before a noteworthy Portland audience, the East Side Commercial Club, by a distinguished gentleman who does not fool easily, Dr. U. G. Dubach, professor of political science at Lewis and Clark college.

Headed "Dr. Dubach Sees Ruse in Vet Bill," the news report went on to state that Dr. Dubach warned of the administration's leanings toward socialized medicine, that he considered recent approval of the new veterans' hospitalization bill a carefully-planned maneuver toward socialized medicine, warned that unless American people stood up to this they would stand in line waiting their turn at a "political doctor," and concluded that the only hope for the preservation of the American way of life lay in a great spiritual

awakening to restore appreciation of the values of human liberties as set forth in the Declaration of Independence.

Your correspondent felt it was nice of the *Oregonian* to report Dr. Dubach's remarks, if only in summary. But something seemed wrong. It could not be Dr. Dubach's conclusions, because your correspondent likewise is extremely dubious about the growth, both central and marginal, of Uncle Sam, M.D., and especially in the region of nonservice-connected disabilities linked with the Veterans' Administration.

Then the something not in harmony became clear. The Dubach news item was well buried, back on page seventeen!

Your correspondent is well aware of the several factors, including the editorial prerogative, which determine the relative value and positioning of news stories. Consequently the glow of satisfaction which he was about to feel for the newspaper rapidly subsided, and he was prepared to be downright sad. But a philosophical thought saved the day and resulted in the chuckle previously reported.

After all, the paper was being thoroughly human, refusing to get much excited when the other fellow's house is on fire, but shouting to high heaven when it thinks its own lodgings are about to be consumed.

Your correspondent thinks the *Oregonian* is quite correct in appraising the presidential order as inviting impairment and destruction of the fundamental freedom of the press. He hopes it and all other publications will continue to sound the alarm. But he would feel much better about the business if it would also remind its readers of the even more essential point that in a nation founded on the principles of liberty and freedom it is mighty difficult to impair or abolish one segment without involving all the rest in the same process.

The press generally seems to have recognized the blow on the noggin—or the danger to its pocketbook—as represented by the presidential order of ill repute. Let us hope it will not require repeated doses of the same treatment to get the point across that we are all in the same boat.

GORDON LEITCH

Functioning at Last

Some years ago, and upon a few intervening occasions since, this section questioned the lack of functioning of our state society's Committee on New Business, suggested that such a committee be put to work or be cut out of the House of Delegates structure.

These criticisms, intended to be constructive, were stimulated by the fact that at each session of our House of Delegates a Committee on New Business was duly appointed by the Speaker, and that ended the matter. There was an abundance of "new business" introduced to successive houses of delegates but little or none of it seemed to reach the Committee on New Business. Most of the criticism was directed, not at the idea of such a committee and its recognized usefulness, but solely at the fact that it was not able to function.

At the October annual meeting a different story was told. The Committee on New Business consisting of Morris K. Crothers, Salem, chairman; A. T. Blanchat, Lebanon, and Alfred C. Hutchinson, Portland, not only was permitted to function, but also delivered a noteworthy performance.

The use of the term "permitted to function" is deliberate, because it is obvious two conditions must prevail for the committee to work. First, questions presented to the delegates must be referred to it for consideration, either by the Speaker or by vote of the delegates, a course which has not always been advisable in the past because many of the problems confronting the delegates were of a special nature and frequently involved special or standing committees. Second, sufficient time must be afforded the committee for its deliberations. Given these conditions such a committee, as was demonstrated in October, can save considerable time and debate for the delegates by its screening efforts. But it is apparent any new business committee will continue to have difficulty doing its

best work during any one-day convention of delegates. Its best performance is likely to follow when sufficient time is available for hearings to be held before any report is submitted. Under such conditions it is a valuable asset and should be retained.



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Change: You see what Pete has topside this column, a nice new printer's cut, complete with caricature? That's fine, except it should be properly understood any resemblance to the character topside is purely coincidental, includin' the anterior protuberance, which we haven't had much time lately to lay in bed for, but are considerin' goin' to work on. Yah, I know sentences shouldn't end in prepositions but that is the way the words come out. You wanna know how come all this fancying?

Ye boss editor up and tapped us. Sezze, Pete, you're a helluva pest, which is to say you are now full growed as pests goes and we think you should be acquiring some dignity (ever heard of a pest with dignity?) now that some of the subscribers are quotin' your stuff which therefore they must be readin'. We aim to give your outburstings a formal head and you a by-line. Which is the same as a legit corporation makin' you third assistant to the fourth vice-president in lieu of other emoluments, only NORTH-WEST MEDICINE isn't structured for that kinda shenanigans. How about it, sezze?

Under that kinda coaxing what is a fella to do? But we got to thinkin' and came up with a compromise. The fancy head is o. k., but by-pass on the by-line. A monicker line would look like Pete was writin' this stuff by hisself when as matters stand all he does is write down some things and add a little touch here and there to the efforts of others which gets called to his attention, provided the happening is authentic and checkable, preferably has an unusual or humorous twist. Few names get mentioned, as we don't aim to embarrass anyone which has a lapse and gets picked off second base with his behavior down.

On second thought mebbe there's a different explanation. Seems we mentioned Editor Hartley twice in same column and lookit what happened. Hey, Hartley, you readin' this?

* * *

Inflation: Milton and Freewater, adjacent but separate cities for long time, got together on joint sewer or water bonds (anyway it's water, whatsa difference if it's comin' or goin'?) which were good investments for those with dough. But municipalities had pesky habit of deducting two-bit charge when servicing bond coupons, which from investors' viewpoint made sizeable nick in interest return. One investor, curious about the charge, wrote authorities. Explanation came back it was for "messenger" charge necessary for one berg to get coupons over bridge across creek to other town so books could be kept straight. Investor wondered why mails wouldn't do, but accepted explanation anyway.

Comes consolidation, and cities merge. Happy investor figgers his two-bit interest nick will be elimi-

nated. But what happens? Next time he turns in coupons he gets whacked *fifty cents* instead! Now is gum-shoeing around trying to find what's going on.

(Hey, Joe, you sure the bridge still crosses the crick? Maybe the messenger has to swim. You want the guy should get wet for free?)

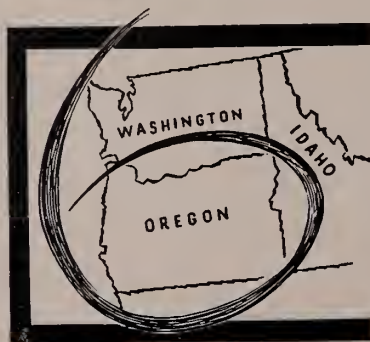
* * *

Half There: Editor Hartley, boss editor of NORTH-WEST MEDICINE, has odd pastime on first visit to new territory. Looks for docs whose names form cardinal points of compass. Seattle has one only. Best entire state of Oregon can do is two, both in Portland, Dr. Floyd South and Dr. Marion Reed East. No North, no West, one disappointed Hartley.

* * *

Whose Program? P.-T. A. meeting in Willamette Valley city waxed boisterous, threatened to get out of hand when parents discovered their younguns were gettin' shoved through classes without learnin' much about U. S. A. Asked to repeat American Creed, couldn't do it; knew flag salute, as about all. Sez one mother (naturalized from Norway): "I hadda know more about this country to get citizenship than my child does who was born here. No wonder strange things happen to us." Soon sundry ma'ams got up to advocate there should be a law compelling such things be taught in schools so kids won't be ignorant. One of few pops present objected. Sezze, state legislature should not dictate to schools what they should teach. Whereupon unidentified gal in back row started

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uproar by reminding in quiet voice the legislature in Oregon had already made law a student cannot graduate from high school without he has put in legal stretch in physical education big muscles program and why should big muscles get preference over knowin' America? Nobody gave answer, which shoulda been something like this: Legislators know who lobbies for compulsory big muscles, but who lobbies for U. S. A.?

(You Willamette Valley boys think your educational facilities is mixed up? You should go to Portland where they really got things confused!)

* * *

Fancy Meeting You Here: Leslie A. White, Eugene medico not averse to participating in humorous incident, pulled fast one on unsuspecting pal who introduced him to Herb Hartley, visiting from Seattle at Oregon annual meeting. Sez White, shaking Hartley hand, "I've known Dr. Hartley for twenty years but never met him until this moment," while introducer wonders what kinda bizzness is this bizzness.

Explanation: Both doctors had been taking care of same patient for twenty years until gent was killed in accident. Patient was virtual commuter between Eugene and Seattle, White taking care of him at one end and Hartley at the other (o. k. you anatomy sharks, make somethin' outa it if you must), with patient relaying messages and comments between docs. Meeting in Portland provided first opportunity for two medicos seeing each other in the flesh.

* * *

No Kidding: Female treasurer of Portland private school mothers' rummage sale to raise scholarship fund during course of sale took day's proceeds to bank. Made hurried trip past sale locale, picked up briefcase containing load of small denomination greenbacks, and accompanied by law officer, presented it to receiving teller of bank with apologies for not having deposit bundled. When teller opened case, spotted vast quantity of loose bills, she was prepared to hear explosion of naughty words, but was totally unprepared for this comment: "Migawd, lady, don't let Harry hear about this or his gang'll think up a new tax!"

* * *

In Form: Oregon docs and *Med. Economics* hold widely divergent views on subject of Oregon Society's executive secretary. October throwaway had article lauding execs as men who make societies tick, printed fotos of eleven, also named some of these and others not fotoed in the text. Conspicuous by absence of both name and foto: Oregon's Clyde C. Foley, recently honored for twenty-five years of continuous service with testimonial banquet, gift automobile, and medical society membership.

How come? Opinions differ. Fine example of throwaway journalistic accuracy and completeness, sez one. Foley fotos are scarce as day *without* scandal in Big Windy, D. C., sez another. Foley has no personal publicist, would throw out on his you know what any gent actin' like one. Throwaway writers has trouble seein' west of Mississippi River, leave alone out to far-away Oregon. Take yer choice.

Least disturbed by performance: Foley.

Way Out East: Gents responsible for operation of Western Conference of Medical Service Plans (eleven Western states and Hawaii) which collectively embody widest range of experience, including problems and defects in these plans, are slightly perplexed by the request from Canadian medical plans to participate in all Western Conference deliberations. Request made for *all* Canadian plans, including Maritimes Medical Service, of Halifax, Nova Scotia, which is about as far east as a gent can go without gettin' wet in the Atlantic. Can't figger out whether to be complimented for fact Western Conference enjoys rep as working conference, or just to be plain flattered for living in right part of country.

Board of Medical Examiners, State of Oregon

January 3-5, 1952—University of Oregon
Medical School

January 3—Chemistry & Toxicology, Hygiene & Public Health, Pathology, Practice of Medicine, Practice of Osteopathy.

January 4—Anatomy, Bacteriology, Physiology & Histology, Obstetrics & Gynecology.

January 5—Materia Medica & Therapeutics, Diagnosis, Surgery, Pediatrics.

Application forms and general instructions may be obtained from the State Board of Medical Examiners, 609 Failing Bldg., Portland 4, Oregon. Applications with all documents must be filed with the Board office not later than December 14, 1951



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**WASHINGTON STATE
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**ANNUAL MEETING
SEATTLE, SEPT. 14-17, 1952**

President, R. A. Benson, M.D., Bremerton Secretary, Bruce Zimmerman, M.D., Seattle Executive Secretary, Mr. R. W. Neill, Seattle

**WASHINGTON STATE MEDICAL ASSOCIATION
Proceedings of the Sixty-second Annual Meeting in Seattle,
September 9-12, 1951**

(Due to the magnitude of the report and limitation of space, it has been necessary to condense these proceedings. The minutes are on file at the office of the State Association, and may be reviewed there in full.)

House of Delegates

First Session

September 9, 2:00 p. m.

The Sixty-second Annual Session of the House of Delegates of the Washington State Medical Association was called to order by the Speaker, Dr. M. Shelby Jared, in the Junior Ballroom, Olympic Hotel, Seattle, Washington, September 9, 1951, at 2:00 p.m.

Dr. H. V. Larson, chairman of the Credentials Committee, reported credentials of the delegates were in order, and a quorum was declared present.

Minutes of the 61st Session of the House of Delegates were presented and approved as published in NORTHWEST MEDICINE.

New Business

Dr. V. W. Spickard, chairman of the Committee on Revision of the Constitution and By-Laws, read a proposed amendment to Article VI, Section 2, of the Constitution, permitting specialty sections representation in the House of Delegates. Dr. A. O. Adams said the balance of the House of Delegates would be upset if delegates of specialty groups were included, as they would come from the larger communities. Dr. R. D. McClure said Yakima County Society had rejected this idea. The amendment was referred to the Resolutions Committee.

Doctor Spickard read a proposed amendment to the By-Laws on the formation of specialty sections which was referred to the Resolutions Committee.

Doctor Spickard read a proposed amendment to the By-Laws which would create a Professional Standards Committee. He noted this amendment was recommended at the 1950 session, but that his Committee, after due deliberation, did not recommend adoption of the amendment. Doctor Haviland stated this proposal was suggested by the Executive Committee which is constantly asked to fix professional standards for members. The amendment was referred to the Resolutions Committee.

Resolutions

Dr. A. O. Adams moved to amend his Resolution pertaining to the Department of Labor and Industries Fee Schedule, but was ruled out of order. Doctor

Adams outlined recent developments concerning the Department of Labor and Industries Fee Schedule; the possibility of an appeal therefrom; referred to a poll he conducted and suggested the Trustees appoint a Committee to study the question of an optional insurance plan. After general discussion, the Resolution was referred to the Resolutions Committee.

A second Resolution, submitting the Association's Over-All Fee Schedule to the Department of Labor and Industries as a schedule for the care of injured workmen was introduced, and referred to the Resolutions Committee, as were resolutions pertaining to Hospital Medical Staff Meetings and insurance reports.

Uniform Narcotics Drug Act

In accord with a motion passed by the Board of Trustees, Mr. Ralph W. Neill, executive secretary, and Mr. Edward L. Rosling, legal counsel, commented on the new narcotics code.

Report of Officers

The President's message presented elsewhere in this issue was delivered at 11:30 a. m. on Tuesday, September 11, 1951, in the Olympic Bowl.

Secretary-Treasurer Haviland read a supplementary report of the Board of Trustees which was referred to the Committee on Reports.

Speaker Jared ruled out of order a request by the King County delegates (made in pre-convention caucus) that Doctor Benson give a full report of proceedings that led to a contract with the State Department of Health for carrying out the medical provisions of Initiative 178.

A. M. A. Delegates' Reports

Dr. R. L. Zech said, "Three delegates from the W. S. M. A. attended the A. M. A. Convention in June at Atlantic City. All meetings were well attended, particularly those on hospital standardization.

"Dr. Henderson, chairman of the A. M. A. Committee on Hospitals, had several meetings with representatives of the American Hospital Association and it was agreed the Committee on Hospital Standardization would be composed of representatives of the A. M. A., the A. H. A., the College of Surgeons, the College of Physicians, and from Canada. This plan met with House of Delegates' approval, with certain reservations.

"The Speaker of the House appointed a Committee on Emergency Medical Call Service, of which I was a member. In a discussion of blood banks it was

divulged that three million units were used in one year, which makes a replacement plan vital. The Committee on Blood Banks reaffirmed its belief that mass blood banking is inadvisable."

Dr. Ross D. Wright referred members to the details of the proceedings of the House of Delegates in the July 7th issue J. A. M. A. He mentioned the membership problem of the A. M. A., 30,000 members being delinquent, of whom 12,000, it is estimated, may discontinue membership in the A. M. A. "A resolution proposed that the position of the A. M. A. regarding delinquent 1950 dues be re-evaluated." He said medical education has an annual deficit of five million dollars. "The National Auxiliary has contributed \$3,000, California \$100,000 and the Medical Education Foundation itself has given half a million dollars to offset this deficit. A slow-down in individual contributions to the Foundation was noted."

Dr. A. G. Young said, "Dave Beck's appearance at the June meeting had set a precedent. Everyone at the meeting was much impressed by Dave Beck and the national officers are planning to have a prominent labor leader speak at future meetings. Doctor Young stated there were 18 or 19 meetings being conducted at the same time, and it is impossible for delegates to attend them all.

"Maternal welfare was discussed at the Atlantic City meeting, as well as at the Cleveland meeting. Some sources think doctors cannot give adequate maternal care in the small communities and there is a possibility E. M. I. C. measures will be reintroduced."

The Delegates' reports were received with commendation.

Secretary-Treasurer's Report

Doctor Haviland said the financial reports of the Association are available in the Central Office for inspection. "At present the General Fund contains \$65,000.00 and the Defense Fund totals approximately \$66,000.00. At the end of the year the General Fund should total between \$20,000.00 and \$30,000.00; the Defense Fund between \$65,000.00 and \$70,000.00.

"A supplementary membership report indicates the Association has 1,946 active paying members, of whom 1,932 have paid A. M. A. dues. Defense Fund membership totals 1,421."

Doctor Haviland stated his three years as Secretary-Treasurer of the Association had been most interesting. "Our State Association has come of age. National and State politics have required work and study. Many matters concerning us as individuals as well as doctors, such as Socialized medicine, welfare issues, problems of Civil Defense, Selective Service, nursing education, fee schedules, emergency medical care, grievance committee work, problems of medical ethics and others have received the consideration of this group. It has been difficult at times to keep expenses down when the Association is asked to participate in so many activities."

The report was adopted.

Finance Committee Report

(Copy on file at Central Office)

Dr. V. W. Spickard, Finance Committee Chairman, made his report which was approved.

Legal Counsel Report

Mr. Edward L. Rosling, Legal Counsel, read his report, which was accepted with commendation. The report is on file in the Central Office.

Public Relations Report

Mr. Howard L. Barnes, Public Relations Director, read his report which was accepted. (This report was published in NORTHWEST MEDICINE last month.)

Initiative No. 178

At the request of the House of Delegates, Doctor Benson made the following statement concerning Initiative 178: "There is no particular report to make further than that duly recorded in the House of Delegates Report Book by the Advisory Committee to the State Department of Health. Actions taken by this Committee are a matter of record and the Advisory Committee will stand on that report."

The First Session of the House of Delegates adjourned until Wednesday, September 12th at 2:30 p. m.

Report of Board of Trustees

Since the 1950 session of the House of Delegates, the Board of Trustees held four meetings.

In addition to carefully reviewing Executive Committee reports the Board of Trustees has taken the following action:

1. Reviewed and approved the annual budget, after suggested changes.

2. Reviewed and approved the Secretary-Treasurer's reports.

3. Selected the "Outstanding General Practitioner of the Year" for Washington, Doctor Harry E. Rhodhamel of Spokane.

4. Approved of the Executive Committee's action in sending a list of nominees from the Ophthalmology and Otolaryngology Section for appointment to the Medical Eye Advisory Committee, State Department of the Blind.

5. Appointed the following Association Committees: Professional and Hospital Relations Committee, Industrial Insurance and Health, Medical and Dental School, Over-All Fee Schedule, Public Relations and approved the Executive Committee as newly constituted.

6. Elected membership of the following committees: Grievance Committee, Public Laws and Scientific Work.

7. Approved Progress Report of Civil Defense Committee and the Report on A. M. A. Committee on National Emergency Medical Service.

8. Directed the Secretary-Treasurer to write County Medical Bureau Presidents suggesting they adopt the new over-all fee schedule as their own. Also directed the fee schedule be sent to the State Department of Labor and Industries and ask that the Department give it consideration when drawing up a new fee schedule.

9. Referred the amended resolution regarding schools of nursing adopted by the House of Delegates to the newly appointed Advisory Committee on Nursing Education and requested the Committee to submit its recommendations to the Board of Trustees.

10. Requested the Committee on Revision of Constitution and By-Laws to study the problem of defining the status, composition, and control of the various authorized sections of the W. S. M. A., and that the Committee propose the necessary changes in the Constitution and By-Laws.

11. Approved the reactivation of the Committee on Proposed Legislation relative to Medical Examiner System. Approved oral report of the Committee which stated proposed legislation would be submitted to all groups in any way related to the coroner's business

for approval. In this manner desired legislation may be effected.

12. Approved additional members to the Committee on Professional and Hospital Relations.

13. Accepted the resolution, adopted by the Executive Committee, of the Washington State Dental Association that professional personnel disqualified for military service because of minor physical defects be re-examined at intervals, rather than be given permanent deferment.

14. Approved the reports of A. M. A. Delegates on A. M. A. Convention at Cleveland.

15. Reviewed and approved Rules and Regulations governing the Grievance Committee. Instructed the Secretary to encourage formation of Grievance Committees on a County level.

16. Instructed Legal Counsel to prepare appropriate legislation to amend the present laws governing practical nurses and registered nurses to provide for medical representation on both examining boards; requested the Executive Secretary to ensure such pieces of legislation are properly submitted.

17. Approved a resolution from the Arkansas Medical Society regarding treatment of veterans for non-service connected disabilities in VA hospitals and directed that copies of the resolution be sent to Congressmen and Senators of Washington State for information.

18. Approved formation of a Committee on Professional Standards and recommended that By-Laws of the Association be changed to permit the House of Delegates to elect such a committee and that the duties of such a committee be clearly defined.

19. Elected the following to the Nominating Committee: Drs. Herman Brundage, Jesse W. Read, Ralph H. Lee and Walter Ebeling.

20. Approved the election of Dr. Quentin Kintner to a vacancy on the State Health Council.

21. Approved report of the Grievance Committee as amended. Recommended procedure set up by the State Grievance Committee be adopted by component societies.

22. Approved nomination of eighteen honorary members of the W.S.M.A. to associate fellowship in the A.M.A.

23. Approved the Executive Committee's action in engaging Mr. Howard L. Barnes as public relations representative and field man for the Association. Reviewed and approved suggested public relations program.

24. Approved the executive secretary's legislative report on Initiative 178, Teaching and Research Hospital, Basic Science Law, Practical Nurses Bill, Optometry Bill, Chiropractic, Taxation and other allied subjects; commended the executive secretary and public relations representative for their fine work during the legislative sessions.

25. Approved an amendment to the By-Laws of Pierce County Medical Society permitting the formation of a Grievance Committee.

26. Approved the Executive Committee's policies relative to implementing the program of Initiative 178:

1. The minimum services which are to be provided in the care of indigents are to be defined by the State Department of Health. Expert consultation will be obtained by the department in the development of this definition, as well as in carrying out its intent.
2. There is to be established a general statewide policy which will be augmented by such local interpretation as is necessary.
3. There is to be quarterly allocation of funds to counties on the basis of proportionate case loads.

27. Instructed legal counsel to file appeal from the Department of Labor and Industries Fee Schedule, subject to the action of the House of Delegates.

28. Considered the possibility of sponsoring an optional insurance plan for the Department of Labor and Industries.

29. Approved formation of a committee to stimulate interest in the various county societies in order to raise funds for the American Medical Education Foundation.

30. Discussed the work done by the Advisory Committee to the State Department of Health during the past year.

31. Appointed Drs. Speir and Reekie of the Nurse Planning Council (Department of Licenses) as ex-officio members of the Committee on Nursing Education of the W.S.M.A.

32. Directed that legal counsel's opinion, obtained at the request of the Washington State Nurses Association, Inc., on the practice of registered nurses giving intravenous injections or of drawing blood from walking donors, be forwarded to that Association.

33. Requested the executive secretary to inform the House of Delegates of the provisions of House Bill 14—Uniform Narcotic Drug Act.

34. Considered a request for contributions from the Marcus Whitman Memorial Foundation.

35. Referred to Dr. Benson a request from the Practical Nurse Association concerning its Civil Defense Program.

36. Approved the Executive Committee report.

K. L. PARTLOW, *President*

(The above report was approved.)

Committee Reports

(All committee reports were referred to the Committee on Reports. Final action as taken during the second session of the House of Delegates is noted after each report.)

Aging Population and Chronic Diseases

This committee held one meeting during the year.

Duties of this committee, at present, are to (a) assemble literature, data and factual information, (b) cooperate, so far as is practicable, with existing local, county, state and national medical groups, industry, labor, social and welfare and governmental agencies.

The labor and expense involved in surveys is usually considerable; our Association must therefore seek the aid of established official and governmental agencies. Our committee recommends to the Executive Committee:

1. That the governor be requested to appoint an over-all committee to study the problems of the aging population and the chronically ill in this state. There needs to be some organization of the community, the state, the county and the city with wide representation of all groups and agencies concerned with this problem to develop and integrate this program.

2. That this Over-all Committee make a state-wide survey of the aged and chronically ill and the categories in which they should be placed.

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3. That the Over-all Committee determine the basis of cooperation and assistance from the State and County Health Departments, State and County Health Councils, the National Commission on Chronic Illness and the U. S. Public Health Service.

4. That the Over-all Committee determine what financial assistance can be expected on county, state and national levels.

5. That the Over-all Committee study existing institutions and the manner in which they may be improved towards higher standards of care.

BURTON A. BROWN, M.D., *Chairman*

(Recommendations in this report were rejected and the report ordered filed.)

Civil Defense

"Spade work" can best describe the work of this committee since last September, and the spade has been effectively used. Organization has gone forward. Plans have been prepared only after diligent effort on the part of many of our state's doctors and groups allied with our profession. But it has been impossible to implement these paper plans as no funds were available for material. That serious deficiency will soon be partially rectified since, as of July 1, 1951, the federal government has appropriated and allocated to this state \$252,000 to be matched jointly by state and county funds for medical supplies only. No federal funds are available for other phases of civil defense.

Main events of this year's work are:

1. A course in Medical Aspects of Atomic Warfare.
2. Formation of six sub-committees to make specific recommendations relative to their individual fields.
3. Two meetings of State Department of Health personnel and the representatives of the Association.

The three-day course at the University of Washington in October was an outstanding success, attended by 461 doctors. Speakers were expertly chosen to cover clearly a segment of knowledge little known to the audience. Proceedings were boiled down into a veritable manual on the subject by Dean Turner of the Medical School.

The Civil Defense Committee meeting on September 10, 1950, in Spokane resulted in the authorization to appoint five sub-committees to make specific recommendations within their individual fields. These fields were (1) Burns, (2) Hospitalization, (3) Laboratory, (4) Blood and (5) Radiological Defense. (Subsequently a sixth sub-committee to cover First Aid was appointed.) All of these sub-committees submitted excellent reports which were formally accepted at the meeting on April 29, 1951.

Two meetings of the entire Civil Defense Committee were held, the first on December 3, 1950, and the second April 29, 1951. Both were well attended by personnel of the State Department of Health who are in immediate charge on the state and county levels, and by members of our Association, either as sub-committee chairmen or county chairmen.

Dr. Leibly represented the State Association at the Fourth Regional Meeting of the Council on National Emergency Medical Service of the A.M.A. in San Francisco, October 1, 1950. Dr. Whyte took part in the radio program, Your Olympia Report, January 23, 1951, which dealt with developments in the medical aspects of civil defense.

Your committee wishes to thank Dr. John A. Kahl, acting director of the State Department of Health, and Dr. Paul D. Mossman, assistant director for medical services in the State Department of Civil Defense, for their consistently fine spirit of cooperation. The real load is on their shoulders since the whole program is set up to function under their leadership.

KENNETH G. WHYTE, M.D., *Chairman*

(This report was ordered filed and the committee was commended for its work.)

Diabetes

The Scientific Exhibit of the American Diabetes Association was again on display at the 1950 meeting

of the Washington State Medical Association held in Spokane. Besides there was demonstrated the rapid blood screening test as devised by Wilkerson and Heftmann and many new pamphlets including the Diabetes Guide Book for the Physician as prepared by the National Association were distributed. Laudable interest was shown by the lay in the educational film strips on pertinent diabetic topics at the Hall of Health. Also the rapid blood sugar screening test was introduced to the populace at the Western Washington Fair in late September, as well as the diabetic charts so ably assembled by the members of the Joslin Clinic and the Metropolitan Life Insurance Company.

Prior to the onset of Diabetes Week in November, 1950, members of the Washington Diabetes Association and the Diabetes Committee of the W.S.M.A., with the aid of the Pharmaceutical Association and the Public Health Service, adopted the ingenious St. Louis Strip as a new contrivance for supplemental testing. Over 22,000 of these strips were made available in nearly all drug stores in Greater Seattle and King County alone.

Experience in the past two drives revealed that about 12 per cent of the total number of free urine tests available for the populace to use during Diabetes Week were utilized. However, figures on the results of the third drive during its recent advent in Greater Seattle and King County where the St. Louis Strip was newly introduced showed a return of 16.4 per cent. One can expect at least 3 per cent of glycosuria in the urines examined. Our early figures amounted to 3.93 per cent. Roughly, one-third represents old diabetics who are checking on their tests, one-third proves to be glycosuria without hyperglycemia and one-third new diabetics.

During Diabetes Week, when the urine test was positive for sugar, it was highly urged that the individual report to the family physician for further testing of urine and blood samples. If newly discov-

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ered diabetes was ascertained, the individual was referred to any physician who was interested.

In early July the 1951 Postgraduate Assembly in Endocrinology Including Diabetes, which took place in Seattle, lent its national merit by having twenty-five outstanding speakers. The Lay Society of the Washington Diabetes Association was honored by the delivery of popular talks on diabetes by ten members of its faculty. Nearly 300 diabetic patients and family members listened with intense interest to these essayists.

JAMES M. BOWERS, M.D., *Chairman*

(The above report was ordered filed.)

Executive

Since the 1950 Annual Meeting, the Executive Committee has held eight meetings, during which it reviewed all bills and expenditures, assisted in preparing the budget, supervised its control and designated various officers to attend local, state and national meetings deemed necessary.

A report on all important actions taken by this committee has been made to the Board of Trustees during the year and many problems were referred to the trustees for consideration before action was taken.

In addition to routine communications and inquiries addressed to the Central Office, the committee reviewed and acted upon the following major items:

1. Reviewed and approved minutes of the 1950 sessions of the House of Delegates for publication.

2. Referred to various committees of this Association many matters for recommendation and advice.

3. Cooperated in every possible way with the A.M.A. and Whitaker and Baxter in their activities.

4. Set meeting dates for the Board of Trustees and prepared the agenda for those meetings.

5. Cooperated in every possible way with various sections of the Association and with other health organizations in promoting programs. Various committees and sub-committees were created for these specific purposes.

6. In compliance with requests from various government departments appointed members of the Association to committees to study pertinent problems.

7. Approved a suggestion that the Speaker of the House, when naming the Reports and Resolutions Committee, carry over one member in order to facilitate and expedite committee work.

8. Laid preliminary plans for the consolidation of offices with allied organizations such as the King County Medical Society, King County Medical Service Bureau, etc.

9. Reviewed and approved an agreement between Northwest Medical Publishing Company and the Association regarding payment of NORTHWEST MEDICINE subscriptions for membership.

10. Authorized the mimeographing of the Constitution and By-Laws of the Association and directed that copies be made available to the county societies.

11. Authorized Dr. V. W. Spickard, chairman of the Finance Committee, to sign checks because the president and president-elect reside out of Seattle.

12. Reviewed and approved the planning of the Volunteer Washington State Advisory Committee on the selection of doctors, dentists and allied specialists under Selective Service, under the chairmanship of Dr. A. O. Adams, Spokane. Authorized administrative assistance to the chairman.

13. Approved the employment of Mr. Howard L. Barnes as public relations representative and field man for the Association; reviewed and approved the proposed public relations program in general.

14. Disapproved the use of W.S.M.A. letterheads and mailing list in sending out sales letters by the Metropolitan Casualty Insurance Company of New York to county medical societies regarding health and accident insurance policies.

15. Approved the contribution of \$25 to the Marcus Whitman Memorial Fund.

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LABORATORY DIAGNOSIS

16. Urged the American College of Surgeons to continue its hospital standardization program until the A.M.A. and other interested medical groups can join in financing the program.

17. Received a report relative to the establishment of a rehabilitation center. Expressed the opinion through the Association's representative to the State Committee on Rehabilitation that such a center be under private management on a non-profit basis.

18. Approved eighteen doctors as eligible for 1951 W.S.M.A. honorary membership.

19. Approved the initiation of "The President's Page" in NORTHWEST MEDICINE.

20. Received and approved a progress report from the Professional Relations Committee and approved change of name to Professional and Hospital Relations Committee. Recommended to the Board of Trustees that membership in this committee be increased.

21. Met with the governor and the director of the State Department of Health and spent much time cooperating with the Advisory Committee to the State Department of Health in considering the problems inherent in the implementation of the medical care program under Initiative 178. The State Department of Health indicated that the resultant policies (see Item 26 of the Report of the Board of Trustees) would be used as a basis for drawing up plans of operation.

22. Approved the Finance Committee's recommendation that the Washington State Medical Bureau contribute the sum of \$5,000 to carry out the Public Relations program.

23. Devoted much time and study to various items of proposed legislation such as clinical laboratories, licensing of nursing and maternity homes, office of coroner, equalization of tuberculosis cases, handling of public health district funds, establishment of hospital districts, birth and death certificates, adoption of minor children, the basic science law, Medical Practice Act, practical nurses act and others.

24. Supported Dr. A. O. Adams and the Over-All Fee Schedule Committee in its efforts to meet with representatives of the Department of Labor and Industries to try to work out a fee schedule which would be mutually satisfactory.

25. Enlarged the membership and increased the scope of the Committee on Aging Population to include chronic diseases.

26. Requested and obtained from the Pierce County Medical Society a statement concerning the work of Dr. Hinton Jonez in his treatment of multiple sclerosis in order to answer numerous requests concerning Dr. Jonez' work.

27. Reviewed and approved the action of the Grievance Committee on a number of matters brought before it. Referred other matters to that committee for consideration.

28. Requested County Medical Societies to appoint committees in order to support the program of the American Medical Education Foundation. Suggested that NORTHWEST MEDICINE and the public relations

director disseminate information concerning the Foundation.

29. Referred to the president for action the request of Dr. Raymond B. Allen, president of the University of Washington, that Dr. Partlow undertake the responsibility of organizing a state-wide committee representing the W.S.M.A., State Hospital Association and the State Nurses Association to act on the recommendations of the University of Washington Advisory Committee on Nursing Service and Training Program Committee report.

30. Discontinued membership in the Conference of Presidents and Other Officers of the State Medical Associations.

31. Approved final report for the 1950 Convention which showed a net deficit of \$21.87.

32. Reviewed and approved the Public Relations Committee proposed "Code of Cooperation with Press and Radio"; approved its publication in NORTHWEST MEDICINE and distribution to members of the Women's Auxiliary.

33. Approved issuance of invitations to members of the Student A.M.A. of the University of Washington Medical School to attend our Convention; approved payment of \$100 toward expenses of one delegate to their meeting in Chicago in December; recommended that the Student A.M.A. be provided with its own page in the *J. A. M. A.*

34. Approved legal counsel's opinion concerning refund of dues to members called into the Armed Forces.

35. Approved the proposed Constitution and By-Laws of the Ophthalmology and Otolaryngology Section.

36. Referred to the Trustees the matter of establishing a Committee on Professional Standards.

37. Reviewed and approved a report from the Committee on Proposed Legislation re Office of Coroner and authorized the committee to continue follow-up work on the medical examiner problem in order to present satisfactory legislation at the next regular session of the State Legislature.

38. Received a report from the State Department of Social Security concerning the limitations under which ophthalmologists may perform eye surgery for the Division of the Blind.

39. Received a report through the A.M.A. that the Social Hygiene Association alleged several physicians in the State of Washington had examined and certified prostitutes as being free from venereal disease. It was suggested to the Social Hygiene Association that they refer the matter to the Washington State Grievance Committee for appropriate action.

40. In accord with a request from the Central Diagnostic Laboratory in Wenatchee, a letter was sent to Chelan and Okanogan counties relative to the toxic effects of organic phosphate insecticides on workers.

41. Agreed to pay one-half of the publication cost of the booklet entitled "Better Nursing" which is a

report of the Advisory Committee on Nursing Service and Training Programs of the State of Washington.

42. Reviewed and approved a motion of the State Bureau relative to increasing the fee for disability assistance examinations from \$5.00 to \$7.50.

43. Accepted with commendation a progress report from NORTHWEST MEDICINE.

44. Approved a report of the Nominating Committee meeting held July 14 with the exception of a recommendation that the sum of \$5,000 be set aside in the annual budget as a stipend for the president of the Association.

45. Approved a proposed brochure submitted by the Heart Association outlining services available to cardiacs in Washington State.

46. Suggested to the Federal Civil Defense Administration that Admiral Dan Hunt (retired) of Tacoma might be available to accept employment as regional medical officer for the Seattle Regional Office of the Civil Defense Administration.

47. Referred to the Civil Defense Committee a request from the Practical Nurses Association that "instructions be directed to them through the medical profession" as the practical nurses prefer to work with this Association rather than with the registered nurses in civil defense planning.

48. Received a legislative report on developments at the special session of the Legislature.

(The above report was approved with the exception of Item 29, which was considered with the report on Nursing Education. That portion of that report dealing with such a committee was deleted.)

Federal Industrial Rehabilitation Program

The Advisory Committee to the Federal Industrial Rehabilitation Program of the Washington State Medical Association submits for your consideration its annual report for the year 1950-1951.

This committee has been inactive and there were no official meetings held.

BRIEN T. KING, M.D., *Chairman*

(Committee on Reports stated: "The Association cannot afford to be out of touch with anything as important as a rehabilitation program and the committee believes the Committee on Rehabilitation Program should be criticized for not having informed the House of activities of the Division of Vocational Rehabilitation.")

(The report was ordered filed.)

Graduate Medical Education

At a meeting of the Graduate Medical Education and Hospitals Committee on Thursday, January 18, 1951, it was unanimously decided the W.S.M.A. should continue to offer the Post-Graduate Course in Surgery, also the Post-Graduate Course in Internal Medicine.

It was believed advisable to keep the doctors in actual practice in contact with the graduate teaching and by this means we would also have qualified members throughout the state participate in the post-graduate course put on by the Association.

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It was decided that in the two courses, doctors from various parts of the state would be represented.

Also discussed at this time was the possibility of sending teams to different sections of the state and the University of Washington Medical School members indicated they would be glad to send out teams, if county medical societies invited them, but that the county society involved should underwrite the traveling expenses.

The Post-Graduate Course in Surgery was presented from March 19 through 23, 1951. Drs. Raymond L. Zech, Ralph Loe and David Metheny gave much thought to organizing this course and the subjects offered each morning and afternoon were confined to specific fields of general surgery. Attending were thirty doctors who paid tuition fees, as well as doctors from Fort Lawton and Fort Lewis who were invited to attend.

The consensus was that the course was well arranged and one of the most practical courses we have given.

This committee agreed to sponsor the following courses in conjunction with the University of Washington School of Medicine and the State Department of Health:

Gynecology, April 2 through 5
 Practical Psychiatry, July 23 through 27
 Electrocardiography, July 19 through 21
 Neurology, August 3 and 4
 Obstetrics, August 6 through 10
 Hematology, September 10 through 14
 Diagnosis and Treatment of Infectious Diseases, October 1 through 3
 Oncology, different periods through the year.

We owe a debt of gratitude to the management of the King County Hospital, to advisory members of the committee and to doctors who assisted in arranging the programs and to the Auxiliary members who assisted.

JOHN K. MARTIN, *Chairman*

(The above report was ordered filed and the committee commended.)

Grievance

Since the Grievance Committee was implemented in March, 1951, we have met either as a whole, or in regional committees, and have rendered decisions on the cases presented to us, two of them involving charges against medical societies. One of these was settled without a hearing and in the other a hearing was held by the whole committee. The decisions are matters of record.

I feel that the Grievance Committee has functioned in a highly satisfactory manner and, as chairman, I could not wish for better cooperation from the members.

JAMES H. BERGE, M.D., *Chairman*

(The above report was ordered filed, after the Committee on Reports questioned "if there could be some machinery whereby a better understanding of what is going on could be commuted to the delegates without revealing things that are better left unsaid.")

Industrial Insurance and Health

The activities of this committee for the past year have been directed toward dealing with the State Department of Labor and Industries in an effort to obtain a new fee schedule that would contain a more complete listing and that would authorize adequate fees under present economic conditions.

In January, 1950, the Department of Labor and Industries was prepared to publish a new fee schedule which granted increases to the hospitals and others but which made no change in the pre-existing fees for doctors. At the request of Dr. Nichols, who was then chairman of this committee, this schedule was not published. On May 31, 1950, Dr. Nichols presented to the department for consideration a carefully prepared fee schedule which was later adopted by this House as the "Over-All Fee Schedule."

Without offering this committee or any representative from the State Medical Association an opportunity

to discuss the schedule, the department placed into effect a new fee schedule dated January 1, 1951. This schedule has actually never been published except for a few copies that were released, but it has been used for the payment of bills since that date. This schedule changed only about forty items and the changes were very inadequate. The president of this Association and the chairman of this committee met with the department in Olympia a short time later and were able to point out to the department the inequalities of this schedule. We were given to understand the schedule would not be published and that we would be given an opportunity to negotiate regarding changes and to present our appeal for an increase in rates before representatives of both labor and industry.

The date of this meeting was set by the department for June 28, 1951, and was held in Olympia. The meeting was a "whitewash," for we were not permitted to discuss any specific fees or rules and there was only one representative of labor and one representative of industry present. Also, your chairman and other members of this committee received in the mail on June 26 and 27 copies of another fee schedule which had been drawn up by the department and it was apparent at that meeting that the department was not willing to negotiate further than this schedule which they had just presented. This schedule was also drawn up without consultation with any representatives of the State Medical Association and there were only about twenty more changes made as compared with the schedule which had been drawn up in January. This last schedule is very inadequate and does not meet the approval of this committee.

ALFRED O. ADAMS, M.D., *Chairman*

(The above report was ordered filed and the committee was commended.)

Investigation of Hospitals

(No investigation requested.)

Maternal and Child Welfare

On September 22, 1950, the chairman served as Washington State Medical representative on the Committee on Health and Well Being of the Washington State Council for Children and Youth. A report on medical condition of the children of the State of Washington was prepared. The report was based on the survey carried on by the American Academy of Pediatrics in 1946. A copy of the report is on file at the central office.

On October 3, 1950, the chairman gave the above report to the Washington State Council for Children and Youth. It was accepted by the council.

On December 21, 1950, the Maternal and Child Welfare Committee met at the request of the State Health Department to advise on the Maternity Home Licensing Act. The proposed Act was approved with minor changes.

On December 26, 1950, the chairman presided over a meeting of the Governor's Conference on Children

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and Youth patterned after the White House Conference. The discussion quite early became limited to mental and psychological problems. It was a struggle between the heads of the local groups who wanted practical help and the purveyors of knowledge who kept the discussion on a stratospheric level. There were a few suggestions that would probably give real help and require no practical knowledge from the specialists. A report of the meeting is on file in the central office.

On February 4-8, 1950, the chairman was sent to the Premature Clinic at the University of Colorado as the representative of the State Health Department, apparently with the purpose of obtaining ideas for establishing a comparable unit in this state. The institution is straight government medicine with free child care paid for by the federal government, and with a representative of the Children's Bureau supervising. The charges sound reasonable until it is noted that a great many expenses are covered under education and public health charges. The care of all prematures has been taken from the medical profession of the state and is under one man (full time) with the Children's Bureau directing. I believe the State Medical Association should go on record as being against this type of medical care.

On June 4, 1951, the Maternal and Child Welfare Committee met to advise the State Health Department in developing the regulations governing maternity homes. They approved the department's suggestion of part-time consultant from the university staff with a sub-committee from the Maternal and Child Committee to help.

The revised birth certificates were discussed and it was advised a certain portion be deleted as not practicable.

NORMAN W. MURPHY, M.D., *Chairman*

(The above report was approved with emphasis on the comment regarding the care of premature infants.)

Medical Defense

(This report, on file in the central office, was approved with commendation.)

Medical-Dental School

There has been no occasion for a meeting of this committee during the past year and it is recommended that the committee be discontinued.

DAVID METHENY, M.D., *Chairman*

(The above report was ordered filed and, on motion by Dr. Haviland, the committee is to be enlarged "to permit geographical distribution of membership, of such a nature that a quorum may be obtained when advice and action of the committee are desired.")

Neoplastic

The Neoplastic Committee in formal meeting held July 25, 1951, took the following action:

1. Reviewed the activities and accomplishments of the Washington State Tumor Registry and provided for continuing review. It is the recommendation of the committee the medical profession give the Tumor Registry its continued support.

2. Recommended adoption of the International Classification of Stages of Carcinoma of the Uterine Cervix as the standard classification, so that data regarding diagnosis and therapy have a uniform base of reference.

Members of the Neoplastic Committee continued to serve as physician members of the Executive Committee of the Washington Division, American Cancer Society, and in this way represented the Washington State Medical Association in giving professional leadership and guidance to that voluntary organization.

JESS B. SPIELHOLZ, M.D., *Chairman*

(The above report was approved.)

Nursing Education

Four meetings were held during the year and in addition members attended meetings of the Advisory Practical Nurses' Committee, conferred with repre-

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sentatives of the nursing profession and the Practical Nurses Association and attended meetings of the University of Washington Advisory Committee on Nursing Service and Training Program.

The committee reviewed the tentative recommendations for approved courses in practical nursing (prepared by the State Board of Practical Nurses). After examining this work and conferring with both practical and registered nurses, it became apparent that many conflicts existed between the two organizations which, it was felt, could be ironed out by the addition of two doctors on the Practical Nursing Board.

Discussion with the Edison School, which conducts a very good practical nursing program, the State Board of Vocational Education and the practical nurses indicated a favorable reaction to this proposal. Representatives of the nursing profession were, however, not enthusiastic. This committee proposed to the Washington State Trustees that two medical men be added to the present Practical Nursing Board, which suggestion was accepted and the trustees felt an effort should be made to secure representation on the Nursing Board.

The committee made inquiries through various representatives of the nursing profession which indicated strong opposition to the placing of medical men on the nursing board. Nurses felt that this was their board and that they were a separate profession and as such should set down their own standards and requirements. In addition the nurses stated that there is an Advisory Council, appointed by the governor, to the nurses board on which two medical men sit. They felt that this was adequate cooperation. With this background and a survey of the situation by Mr. Neill, it was felt that further pursuit of this program would create too much friction between the nursing and medical profession; we, therefore, requested permission of the Executive Committee to withdraw any attempt to place medical men on the nurses' board. The Executive Committee agreed.

A proposed amendment to the Practical Nurses Board adding two doctors was drawn up by Mr. Edward L. Rosling, legal counsel. Mr. Neill succeeded in getting this measure passed through the Senate from where it went to committee. Mr. Neill was unable to get the amendment out of committee, chiefly, he felt, because of the effective lobbying of the Nurses Association. This committee feels that, inasmuch as practical nurses work directly under the supervision of the medical men, it is important that they be represented on their board and we failed to understand the opposition of the nursing profession in this respect. Mr. Neill is of the opinion that there will be a greater opportunity to secure passage of this amendment at the next Legislative session if a proper educational program is planned, well in advance of the session.

We are indebted to the exhaustive studies made by your Nursing Committee in 1947-1948 which served to spotlight the nursing problem in this state. As a re-

sult, greater efforts have been made to solve nursing problems than at any time in the past. During the year the University of Washington Committee on Nursing Service and Training Program, under the chairmanship of President Allen, made an exhaustive study of nursing care in this state. They secured the services of Dr. Jean Curran, dean of the College of Medicine State University Medical Center at New York, and Dean Helen Bunge, associate director of study, Frances Payne Bolton School of Nursing, Western Reserve University, Cleveland, as outside observers to make an independent survey of nursing problems in the State of Washington. They visited hospitals and held conferences with doctors, administrators and nurses in many parts of the state. They reported their findings to the committee. Two members of this committee attended conferences and reports, assisting in the final summary which is a booklet entitled, "Better Nursing." This has been published by the University of Washington Press and should be read by all medical men interested in improving nursing.

RALPH H. LOE, M.D., *Chairman*

(This report was approved as printed above. The portion not approved has been deleted.)

Over-All Fee Schedule

A short time ago a notice was sent out from the state office regarding negotiations that have been underway with the Department of Labor and Industries regarding the industrial fee schedule. This notice was in error, however, in that it stated that these negotiations were being made by the Over-All Fee Schedule Committee. This item of business, however, has been conducted by the Committee on Industrial Insurance and Health.

The Over-All Fee Schedule Committee now has under consideration additions to the schedule that was adopted by the House of Delegates last year in the fields of psychiatry, pediatrics, gynecology and obstetrics, but the material was not ready to present to the House of Delegates.

The committee does, however, recommend that the following be adopted as an addition to the present Over-All Fee Schedule:

Insurance reports, completion of.....fee, \$3.00

Statement of Policy—regarding completion of insurance reports:

Patients whose treatment comes under the jurisdiction of prepaid plans such as Department of Labor and Industries, Medical Service Bureaus and Fraternal Organizations and who, in addition, have supplemental coverage, should be charged for the completion of Insurance Reports submitted to those companies offering the supplemental coverage but not for reports submitted to the company responsible for the payment of the medical care.

This policy may also be applicable to private patients where the period of treatment is short and the fee charged is not adequate to cover this additional service.

A fee may also be charged estates for submitting certificates of death to insurance companies for the purpose of collecting on life insurance policies under circumstances similar to those described above.

ALFRED O. ADAMS, M.D., *Chairman*

(The above report was approved and copies were ordered sent to the members of the Association.)

Professional and Hospital Relations

This committee was revised to meet suggestions of the A.M.A., with particular reference to current problems arising from institutional practice in addition to other common professional relationships for which the old Professional Relations Committee functioned.

At the first meeting of this committee, for organizational purposes, it was decided to expand it to represent all the secondary and even smaller urban centers throughout the state, and the agenda for the year, so to speak, was formulated primarily about the in-

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stitutional relationships recently incorporated in the duties of this committee.

In discussion of our hospital relations, relatively authentic rumor brought out the fact that some Legislative proposals were contemplated by persons associated with hospitals, which were to be presented to the 1951 session of the State Legislature. Since on previous occasion an unsatisfactory law relating to professional relations had been erroneously charged to the medical profession, this committee decided to await action of other interested parties before making proposals of any sort. After the Legislature had adjourned and no bill had been submitted and no issue had been drawn, the committee decided to offer an open cooperative round table meeting to the officers of the Washington State Hospital Association for any general considerations which might seem mutually cogent to any problems as they might appear.

This meeting was held on June 21, 1951, and was attended by Mr. Horace Turner, president, Washington State Hospital Association; Mr. Walter Heath, past president of the Hospital Association, and other representatives of hospitals. From introductory remarks it was soon evident there were no major local problems that were well established, that is, local to the State of Washington. What was uppermost in the minds of those present were rumors and reports from developments in hospital management in the East and pronouncements of national organizations.

One local item recorded as existing in Spokane referred to the development of relationships with the new group of M.D. anaesthesiologists. Another item specifically referred to a difference of opinion over relationships between a hospital and a pathologist in Wenatchee, and comment was made concerning a specific anaesthesiologist and a specific hospital in Tacoma. After considerable general discussion, none of which was definitive nor conclusive, the Medical Association representatives agreed to develop information on the points of interest proposed by the hospital administrators as listed above. All present subsequently agreed to a meeting on August 2 for report and further discussion. It was stated at the meeting on June 21 that information would be gathered from the A.M.A. concerning the national policy of the Division of Anaesthesiologists and that representatives of anaesthesiology, pathology and radiology would be invited for discussion of specific relations and proposals. On August 2 these representatives of anaesthesiology, pathology and radiology were invited to meet with the committee at a preliminary conference in order to assemble and integrate various types of information from various sources. This information was presented at an evening meeting with the hospital representatives in direct reference to the agenda items as agreed upon by all parties on June 21. At this time Mr. Turner was offered an opportunity to restate or clarify any problems which he had previously mentioned, or to comment upon them. This he declined to do, stating that he was awaiting official action of the

State Hospital Association at its September meeting before being willing to make any statements concerning his policy in professional relations.

Since this tended to suddenly complete the business of the meeting, the chair decided to open the meeting for general discussion of anything related to medical professional relations with hospitals for the benefit of all those present, that they might bring any reports, make any suggestions, ask any questions or divulge themselves of any comments. After some two hours of relatively free mutual discussion of the various problems and the actual eventual unofficial statement of policy on both sides, the chair asked representatives of the Hospital Association if they would care to continue such meetings at a later date for more definitive discussions and conclusions. Mr. Turner, acting as their spokesman, suggested that we do continue such meetings officially at such later date, namely, after the Washington State Hospital Association meeting. This necessarily entails a new W.S.M.A. committee for that purpose, since it is also subsequent to the Washington State Medical Association annual meeting.

Since most of our active time has thus been consumed in making approaches of friendship to the Washington State Hospital Association, it has not been possible for us to meet with other groups. While we can point to no accomplished facts, nor contractual agreements, nor solution of any specific problems at this time, the committee does feel that this new venture, a round-table discussion of mutual problems, is a step forward.

ASA SEEDS, M.D., *Chairman*

(The above report was approved with commendation and it was ordered that the committee be made a standing committee. Such action requires an amendment to the By-Laws.)

Proposed Legislation *re* Office of Coroner

A special meeting of the committee was held on May 5, 1951, according to the directive to reconsider the apparent differences of opinion between Dr. A. E. Lien and other members of the committee on whether a medical examiner system should be proposed based upon:

- A unified *state* system, with examiners appointed by a state commission, and the financial support coming largely from the state, or
- A medical examiner system organized along a *county-level* plan, with examiners to be appointed locally by the county commissioners, and most of the expenses thereof to be borne by the individual county.

There was a general agreement upon the following:

- A unified state system of appointment and control of the medical examiners is preferred to a system involving appointment and control of medical examiners at a county level only. All are agreed that this would fully represent an ideal system so far as present deliberations have shown.
- Beyond all doubt, there will arise serious obstacles to such a proposal of a unified state-wide system. It will be much more difficult to put across a state-wide system compared to one based upon the so-called county-level plan. These difficulties or obstacles will be:
 - Resistance to any new and large appropriation by the State Legislature (contemplated appropriation is \$250,000.)
 - Probable resistance to the idea by groups or organizations who, on general principles, object to the increased centralization of government and who prefer retention of controls at local levels.

There is a strong possibility that objection to a state-wide system may be strong enough to block it at the next Legislative session. Your committee has considered whether or not it might be advisable, in such an event, to accept as a second best alternative the more easily accomplished change to a medical ex-

aminer system organized along the county-level control plan, such an alternative to be accepted only after it became clear that the first plan had no chance of approval. We believe that such an acceptance of "half a loaf" would be inadvisable and eventually would do more harm than good. In political practice, it is often true that measures which only half correct an abuse relieve enough tension so that years may be required before enough public interest and pressure can again be generated to correct the evil completely. We believe it would be almost impossible in the next twenty years to get a county-level plan changed over to a state-wide plan once the former becomes crystallized in the form of law. If we cannot put across the state-wide plan now, we believe it safer to let the present coroner system fester for an additional two years with corresponding accumulation of the evils and of the discontent with them.

However, these last comments are made only because we must admit the possibility of temporary failure and be prepared for the defense line to be held in that event. We prefer the frame of mind that says success is possible and likely if an all-out effort is made now.

Your committee further realizes that, while the present plan represents its best effort, it is not necessarily perfect for that reason alone. Further study by non-medical organizations is necessary and their counsel should be actively sought. This present plan is the product of one group only, but at least it may serve as a useful point of departure for further intelligent work on the problem.

If this general plan meets with approval, we suggest that steps be taken at once to drive toward our immediate objective which is the introduction of legislation. Much prior work will be necessary in the way of contacting of interested groups and promoting discussion of the entire problem with the general public. The initiative for this and much of the follow-up must



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come from our own profession. We suggest that someone with the experience and capabilities of Dr. Lien would be valuable in directing efforts within our profession and coordinating them with the efforts of others.

Clyde R. Jensen, M.D., *Chairman*

(The above report was approved and the committee was ordered continued to complete its work.)

Public Laws

The Public Laws Committee met on all necessary occasions and reviewed all matters referred to the committee by the state office. Included were:

House Bill No. 61—Introduced by Messrs. Carty, Orndorff and Ovenell.

"An Act to prevent confusion, fraud and deception of the public in connection with the sale of dairy products."

The committee took no action and the bill was passed and is now law.

Senate Bill No. 7—Introduced by Senators Rosellini and Hall.

"An Act relating to children with behavior problems, defective and feeble-minded persons, deaf children, and blind children."

The committee saw no reason to disapprove the proposed legislation. Senate Bill No. 7 passed and is now law.

An Act relating to the welfare of minor children was reviewed and the committee approved the proposed act.

Practical Nursing Bill—This was approved by the committee and the Association and passed the Senate. The House Medicine Committee of the State Legislature refused to consider the bill.

SB 189 Re: Licensing and inspection of Nursing Homes. This bill passed the Legislature and is now law.

B. D. Harrington, M.D., *Chairman*

(The above report was ordered filed.)

Public Relations

Nineteen-fifty was a year of greatly increased activity in the Public Relations field. It saw the nationwide program of the A.M.A. brought to climax in October when a million-dollar advertising campaign was released. The weight and importance of this program were more than trebled by some two million dollars of tie-in space purchased by other organizations which were friendly to medicine and to our free American competitive enterprise system. This resulted, in effect, in a nation-wide referendum of unprecedented scope in which the advocates of free medicine spoke out in unmistakable terms against the threatened encroachment of Socialism into this field. Your Public Relations Committee participated in and kept pace with these developments on a state basis.

Today, thirty-five states, including our own, have specific public relations budgets and are staffed with full-time specialized personnel to assist in the administration of clearly defined public relations programs. Outside counsel were retained on a fee-for-service basis only.

A new and detailed public relations program has been outlined by your Public Relations Committee. It appeared in *NORTHWEST MEDICINE* and has been printed in pamphlet form for distribution. It has been sent to every association member, all Society officers, all Auxiliary officers and members and to a selected list of press, radio and other key organizations and people. It is the committee's hope that this outline will be widely read and widely used as a guide to a more effective public relations activity on the part of every doctor member, for the really effective job in public relations must be done by the doctor himself.

Your committee has also prepared a press-radio code of cooperation as a guide to better relations be-

tween physicians and hospitals and the press and radio. Contacts have already been made with some of the interested parties.

Work in the legislative field was more extensive and demanding than usual, because the extended regular session of the Legislature was followed immediately by a special session. Many measures of vital concern to the medical profession were introduced during these two sessions. A listing of some of the more important of these follows:

The Medical Services Appropriation under Initiative 178 was under the same pressure as other General Fund appropriation measures and was finally set at \$23,377,000, approximately \$6,000,000 under the departmental request. At one point during the legislative consideration of this bill, it appeared it would be cut below \$20,000,000. The University of Washington Teaching and Research Hospital was likewise caught in the wave of pressure against capital outlays. However, one bill passed and signed provides for \$5,000,000, subject to the regents' willingness to bond income from the Metropolitan Tract for that purpose. Additional sums aggregating over \$2,000,000 were ear-marked.

The Basic Science Law remains unchanged, despite numerous attacks upon it.

The Practical Nurses Bill which had been approved by W.S.M.A. started late, passed the Senate and was trapped in the House by an adverse Medicine Committee in the closing days of the Legislature.

An Optometry Bill authorizing licensed optometrists to examine and prescribe for blind applicants was passed.

In the field of taxation, two major threats were defeated. One called for a hundred per cent increase in the Business and Occupation Tax and the other was a threatened tax on professional services.

Among the measures which were enacted, largely proposed by the Department of Health and approved by W.S.M.A. were (1) \$400,000 deficiency appropriation for County Tuberculosis Hospitalization aid. (2) Licensing of Nursing Homes. (3) Regulation of Maternity Homes. (4) Control over adoptions. (5) Budget requirements for county hospitals under the director of health.

The cooperation of individual doctors, in response to staff requests from Olympia, for personal appearances before committees was prompt and effective. Much credit also goes to the Bureau and Society staff people and to the various auxiliaries who helped promptly and in many ways.

The expanded Public Relations Program of W. S. M. A. contemplates personal contact with legislators in all sections of the state, during the period between sessions, in order that they shall have an improved understanding of problems arising in the medical field.

ELIZABETH FABEN, Director

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The public relations director has made many contacts in all sections of the state and is extending these contacts to include the Societies, Bureaus and Auxiliaries as well as others who have a common interest in these endeavors.

All activities of the Public Relations Program are directed toward strengthening our position in the State and nation, to more effectively meet the recurring threats of political encroachment upon the American system of free competitive enterprise, not as an isolated group, but as citizens fighting the broader trend toward complete socialism.

FRANK H. DOUGLASS, M.D., *Chairman*

(The above report was approved and the committee commended.)

Publications

NORTHWEST MEDICINE made remarkable gains during the year in revenue, circulation, and editorial coverage. A deficit of \$3,100.00 for the calendar year 1949 was changed to a gain of \$1,400.00 for the year 1950, a total gain of approximately \$4,500.00 which took the journal out of the deficit category, and enabled it to pay all outstanding loans and meet all commitments. A small increase in circulation revenue plus a \$7,000.00 increase in local advertising was responsible for the changed financial picture. At the January, 1951 meeting of the Board of Trustees an operating budget of \$47,000.00 was approved, providing for expansion of news and editorial coverage, withdrawal from the State Journal Advertising Bureau of the American Medical Association, appointment of a national advertising representative, insurance coverage of all personnel and equipment, bonding of the treasurer and increased circulation costs. The \$47,000 budget authorized for 1951 can be compared with operating costs of \$35,000.00 for 1949 to evaluate the gains made in the last two years.

The first six months of 1951 show a revenue gain of \$3,000.00 over the first six months of 1950, and indicate a gain of approximately \$7,000.00 for the current year due in large part to the increase in rates on national advertising.

Circulation increases in the last two years total 348, of which approximately 205 are for the first six months of 1951.

Editorial and news coverage was greatly improved during the past six months due to action on the part of the trustees in which they named Doctor Herbert L. Hartley and Doctor Clarence A. Smith co-editors and approved the appointment of Mrs. Mae F. Barendregt as managing editor and Mrs. Mary E. Frear as news reporter to assist in handling of the news and editorial matter. Results of this improved editorial setup are evidenced by such items as the Christmas issue of 1950, the Doctor Smith edition published in February, 1951, the wide circulation given "Medicine's Problem Child, the Hospital," which was circulated and reprinted throughout the United States, and the Washington State Convention section of the August journal which went far beyond the usual scope in covering convention activities.

The withdrawal of the journal from the State Journal Advertising Bureau has necessitated the appointment of a new Advertising Committee to pass on advertising acceptance. This committee became effective July 1, 1951 and is composed of the following members: Doctors Fred A. Ellis, Gayton S. Bailey, James W. Haviland, M. Shelby Jared, Donald G. Evans, and Herbert L. Hartley. It is largely on account of the appointment of this Committee and its effect on advertising and editorial policy that the Trustees found it necessary to hold a mid-year meeting in Seattle, July 29.

G. S. BAILEY, M.D., *Chairman*

(The above report was approved with commendation.)

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Resolutions Activating

The directives contained in the resolutions pertaining to the Adoption Code, Birth Records and the Pathology Section have all been complied with.

Concerning the directives contained in the resolutions relative to the Office of Coroner and Schools of Nursing; No conclusions have been reached but there is continuing action in these two matters.

No follow-up action was necessary on the resolution relative to Referendum 28; it was defeated at the 1950 elections.

FREDERICK B. EXNER, M.D., *Chairman*

(The above report was ordered filed.)

Revision of Constitution and By-Laws

The committee drew up one amendment to the Constitution of the Washington State Medical Association which is to be read at this meeting and voted on at the 1952 meeting.

It has also drawn up at the direction of the Board of Trustees an amendment to the By-Laws that adds a new chapter—Chapter XIV covering Sections. It has also drawn up an amendment to the By-Laws covering a Professional Standards Committee. These amendments are submitted with this report with recommendation.

The committee also recommends that the Constitution and By-Laws as drawn and amended over the past ten years be printed for the information of the membership, since it is very difficult to know what is contained in the mimeographed copies.

V. W. SPICKARD, M.D., *Chairman*

(This report was approved.)

Rural Health

There has been no meeting of this committee this year, but under instructions of the Executive Committee this committee will cooperate with the Washington State Health Council in arranging for a state-

wide Conference on Rural Health, which will be held in December or January.

W. D. TURNER, M.D., *Chairman*

(This report was ordered filed.)

Scientific Works

Your committee has held three formal meetings and the chairman of the Scientific Program, Dr. Fred J. Jarvis, has conferred personally with many individuals and organized groups in formulating that phase of the State Convention.

Various sections of the State Association were asked for and made valuable suggestions for the Scientific program and assisted in its final arrangement. Much of the program was the result of a questionnaire circulated among general practitioners.

Every effort was extended by these committees to produce an excellent program, and wherever possible to remove resemblance to former programs. This I am sure they have accomplished, and to them go my sincere thanks and appreciation.

KENNETH L. PARTLOW, M.D., *Chairman*

(This report was ordered filed and the committees were commended.)

State Department of Public Health

In acting in an advisory capacity to the State Department of Health as well as being a committee of the Washington State Medical Association this committee found itself confronted with a dilemma in attempting to work out an equitable solution to the problems imposed by the passage of Initiative 178. This committee met frequently and repeatedly both with the State Department of Health, as well as on its own initiative. It has attempted to maintain constant liaison with the State Department of Health.

It will be readily recalled that the context of Initiative 178 invoked considerable discussion and aroused a divergence of opinion in the House of Delegates last year. The successful passage of Initiative 178 made the controversial items a reality demanding an equitable solution. Our concern necessarily was in connection with the medical care program. Careful estimates were made in an attempt to determine the cost of supplying medical care to the recipients of the various categories of welfare aid. The Advisory Committee, with the Department of Health, formulated a program of prepaid medical service to be conducted through the respective county Medical Service Bureaus on the basis of a negotiative contract. This contract was negotiated through the Washington State Medical Service Bureau on the basis of \$2.75 per month per recipient. The hospital service, drugs and appliances were not included in the contract. Medical only services to be on a fee-for-service basis. This contract was negotiated as of February 1, 1951, and effective March 1, 1951.

On February 27, 1951, the Medical Service Bureau was notified by the State Department of Health of cancellation of this contract, the reason given being the inadequacy of funds.

In the interval the appropriation bill had been passed by the legislature and signed by the governor. Whereas it had been anticipated the \$35,000,000 would be required for the payment of the necessary medical services, the appropriation had been reduced to \$23,377,280. It also became apparent that the estimated case load of 115,000 recipients would, on a revised estimate, approximate 140,000 a month.

A further imposition on the appropriation was the loss of the 2-mill levy with this expenditure chargeable against the total figure. It thus became necessary for the Department of Health with the Advisory Committee to again review the entire problem and attempt to set up a new medical program.

Several meetings ensued with the ultimate proposal by the State Department of Health that prepaid service be furnished on a contract basis with the local

bureaus at \$1.85 per month per recipient. The Advisory Committee set forth three points to which it felt obligated to adhere: (1) Adequate fees for professional services performed; (2) the concise definition of limitation of services by the State Department of Health; (3) the equal and nonpreferential allocation of funds to the respective participating counties.

The State Department of Health did not feel that it could increase its per capita figure and in turn the committee did not feel that it had the authority to obligate itself or the State Association to the acceptance or recommendation of a figure which would jeopardize the three above-mentioned points. In consequence thereof the Department of Health was notified of the committee's unwillingness to accept their proposal.

The Executive Committee of the Washington State Medical Association was notified of the stand of the Advisory Committee. The governor then requested a meeting with the Executive Committee to review the entire program. Further negotiations and settlement to the point of its present operation were conducted by the Executive Committee, the Board of Trustees, implemented by the Washington State Medical Service Bureau.

The committee should like to make it clear that its existence and function was subservient to the Executive Committee and Board of Trustees of the Washington State Medical Association. The committee was of a firm conviction and opinion that its actions and advice would have to be such as to be to the best interest of the State Association as well as providing the State Department of Health with the necessary sound advice and opinion of the medical profession that would serve the best interests of the department, and the recipients of the medical aid. It is quite obvious also to all the members of the Advisory Committee that the satisfactory solution in a medical aid

(Continued on Page 955)

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program for welfare care has not been reached. The committee has been further committed towards attempting to obtain this ultimate solution.

R. A. BENSON, M.D., *Chairman*

(This report was ordered filed and the committee was commended.)

Study of Medical Care Veterans Administration

Since the last report a year ago there has been an entire change in the handling of the Veterans Administration Home Care Program. The original set-up provided that authorization for care was issued to each component bureau throughout the state and they in turn transmitted authorization to the doctors and billed the Veterans Administration for services rendered, and the Veterans Administration paid directly to the bureaus. In December this entire program was taken into the State Bureau office, where all details of the program are now handled. On account of this additional work it was necessary to put on more help, and due to the lack of space in the State Bureau office it was necessary to rent additional space in the Douglas Building. The volume of this work has been running, per month, about 1300 authorizations, amounting to \$16,500.

At about the same time the general accounting office of the Veterans Administration made an audit of the administrative cost of the handling of this program by the local bureaus. The contract provided that the percentage paid should be 10 per cent and that this amount should not develop into either a profit or a loss to the bureaus. In their study they attempted to show that the actual cost of administering this program was 7.65 per cent, and on the basis of this study the Veterans Administration immediately withheld from the remittance to this office the sum of \$6,277.86. In order to keep the program running and to see that the doctors were promptly paid for services rendered the Board of Trustees authorized a withdrawal from the bureau funds in this amount.

The question of whether or not the difference in this administrative cost is correct has not been resolved. Negotiations are still going on.

The contract with the Veterans Administration terminates on each July 1st. This contract, however, has been renewed to run to July 1, 1952, with the following amendment: that instead of paying a fixed percentage for administrative overhead, the Veterans Administration will pay to the State Bureau each month the actual cost of administration. We believe that this is a much better contract in that it will not lead to the confusion we have had in the past.

The thirteen states in the Union who have a program with an intermediary body such as the State Bureau are all operating on this basis.

State Department of Health

Due to the fact Initiative 178, which became law on December 7, 1950, transferred the entire health program from the State Department of Social Security to the State Department of Health, together with the lack of appropriation of sufficient funds to carry on this program on the same basis as that in the prior biennium, a tremendous amount of confusion has resulted and almost the entire time of this committee has been taken up with this problem.

An advisory committee to the State Department of Health was appointed by President K. L. Partlow, M.D., and this committee met many times with Dr. J. A. Kahl, acting director of the State Department of Health, and his staff to try and establish principles of care under Initiative 178. Following this the Executive Committee of the State Medical Association met with the Governor to see if something could be worked out which would be satisfactory to both the State of Washington and the State Medical Association. At a general meeting held January 13, 1951, trustees of the State Medical Bureau and representatives from every bureau in the state worked out an agreement with

Dr. Kahl which gave very limited coverage on the basis of \$1.85 per capita per month. This was for only acute and emergent care and will probably work out to the advantage of everyone concerned. Contracts have been signed by all counties except King, Snohomish, Garfield and Columbia, who are operating at the present time on a fee-for-service basis.

In connection with the administration of the ancillary services the Health Department found that it had a lack of personnel or facilities to set up its own administrative program. As a result, several bureaus have agreed by a separate contract to do the administrative work together with auditing, vouchering, etc., for the entire program.

These contracts provide that this service should be provided on a cost basis, a voucher to be submitted each month. The medical personnel required for screening and authorizing special procedures is also paid by the State Department of Health. The only county that has neither a prepaid plan nor an administrative plan is King County. In this instance the County Health Department has set up an entire personnel office and they perform every function in connection with this health care plan, for which they compensate the doctors on a fee basis for work authorized.

State-wide Contracts

The progress of this program has been rather disappointing due to several factors. Since 1933 the bureaus have been organized and have progressed under the provisions of local autonomy, which did seem during those years as being the only satisfactory way to run this type of program. However, this developed into 22 different types of contracts. Substantially they were very much alike, however, there were items such as salary limitations, excluding provisions, term of treatment and rates covering premiums that varied. Most of these variations could be coordinated, but the provision covering salary limitation seems to be one that has been most difficult to overcome, and has not been

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overcome as of this date. When a bureau program is in competition with an insurance carrier who makes no distinction as to earnings of the subscriber, this has developed into a paramount issue. This is one situation that must be corrected before any degree of competitive contract can be written. Under the new negotiated wage agreements which generally provide for life and dismemberment insurance, together with a weekly compensation, and tied to this a medical program, the basis for the employer participating has been at such a low rate per hour that there has not been the margin to provide insurance required together with the usual bureau premium rate. Inasmuch as the employer has been forced to provide this coverage, he does not feel justified in giving the employees further consideration than that provided by the negotiated wage scale. The answer to this problem is still not resolved and will need a great deal of very serious consideration by everyone concerned.

School Contracts

The bureaus in the last two years have been very successful in effecting an almost over-all state coverage on the athletic program as provided by the high schools and junior colleges. This probably has resulted in the best job of public relations that can be imagined.

Enrollment

The total number of persons covered by all medical service bureau contracts as of June, 1949, was 301,814; in June, 1950, the number was 324,923; and as of June, 1951, the number was 350,570, which is a 16 per cent increase in two years.

Meetings of the Trustees

On December 5, 1950, a special meeting was held, at which time several problems were discussed, among them the appointing of a committee on state-wide contracts. Consideration was given to the report of the bureau managers covering certain procedures which was accepted.

The next meeting was held on January 13, 1951, which had to do principally with the health program as proposed by the State Department of Health and approval of the proposed contract.

On May 20, 1951, was held a general meeting of all bureaus, State Department of Health and county health officers, which again was principally in connection with the Health Department contract.

A special meeting of the trustees was held in Wenatchee on Saturday, July 21. Among the several problems under discussion at this meeting was that of writing state-wide contracts by the State Medical Bureau. The board felt that to function properly and meet the demand for statewide contracts the State Bureau should develop several types of contracts, including insurance coverage, so that a "one package" deal could be offered to those groups who are in the market for a "one package" deal. On this recommendation a committee of five bureau managers was appointed to meet and prepare such a program to be submitted to each of the trustees prior to a meeting to be held on August 12 in Seattle. It is reasonable to assume that at that time some plan as presented will be approved for immediate offering to these groups.

A. G. YOUNG, M.D., *Chairman*

(The above report was rejected on recommendation of the Committee on Reports, which objected to the "State Bureau entering into a contract with the State Health Department, when the bureau was authorized only to draw up a master contract and was not authorized to negotiate the contract." It was ordered that the Committee on Study of Medical Care be reconstituted by the Board of Trustees.)

Teaching and Research Hospital

There has been no meeting during the past year of this committee.

In the report of the Public Relations Committee will be found information on legislative action with regard to the Teaching and Research Hospital. Action of the

Board of Regents of the University of Washington will determine the present status of construction of the hospital.

Thus, it appears there may be some necessity for continuation of this committee for at least another year.

R. L. ZECH, M.D., *Chairman*

(This report was approved.)

Tuberculosis

The Tuberculosis Committee did not meet during 1950-51. However, the members did consider by mail a case-finding proposal to utilize all available mobile X-ray units in the state. This proposal was developed by a planning committee of the Washington Tuberculosis Association and was passed favorably by the members of the Tuberculosis Committee. The proposal was forwarded to the Executive Committee of the Washington State Medical Association with the recommendation that the latter group appoint a member of the Washington State Medical Association to a steering committee, which is to have the responsibility of working out details of the case-finding program.

Several other problems remain for the consideration of the Tuberculosis Committee in the future, among which are: (1) The routine X-raying of general hospital admissions; (2) care of the tuberculous Indian in the state of Washington; (3) proper use of the tuberculin test. Of these three the first, the routine chest X-raying of general hospital admissions, was felt to be the most urgent. However, since the recommendations of the Tuberculosis Committee for 1949-1950 in this matter were received by the House of Delegates but not accepted, it was thought doubtful that further consideration of the subject was in order during the term of the present committee.

DONAL R. SPARKMAN, M.D., *Chairman*

(This report was ordered filed.)

Action on Proposed Amendments to Constitution, By-Laws and Resolutions

Proposed Amendment to the By-Laws

By adding a new chapter, Chapter XIV, as follows:

Chapter XIV, Sections: Any specialty may form a section of the Washington State Medical Association with its own Constitution and By-Laws which must be approved by the Board of Trustees. A specialty section may be considered as a committee of the Association. A specialty section may have programs at the annual meeting of the Association, but only subject to the approval of the Committee on Scientific Work.

V. W. SPICKARD, M.D., *Chairman*
Committee on Revision of the
Constitution and By-Laws

(This proposed amendment was disapproved on recommendation of the Resolutions Committee.)

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Proposed Amendment to the Constitution

Amend Article VI, Section 2, of the Constitution to read as follows:

Section 2. Composition. The House of Delegates shall be composed of (1) delegates elected by the component societies, each component society being entitled to elect one delegate for each 50 active members in good standing, or fraction thereof, who enjoy all the rights and privileges of membership, provided each component society shall be entitled to elect at least one delegate, (2) *one delegate from each approved specialty section*, and (3) *ex officio*, the officers of the Association enumerated in Article V, Section 1 of this Constitution.

V. W. SPICKARD M.D., *Chairman*
Committee on Revision of
Constitution and By-Laws

(The Resolutions Committee recommended that the above amendment "do not pass," and it will be voted upon during the 1952 Convention. *Italic matter indicates the proposed change.*)

Proposed Amendment to the By-Laws

Amend Chapter VIII of the By-Laws by adding a new line to Section 1, as follows: *Sub 14—Professional Standards Committee.*

Amend Chapter VIII of the By-Laws by adding a new section thereto as follows:

Section 16: Professional Standards Committee.

The Professional Standards Committee shall consist of six members, one from each Congressional District, plus a chairman, to serve for a period of one year, elected annually by the House of Delegates.

The duties of this Committee shall be to consider and make recommendations on any matter involving professional standards not within the jurisdiction of the Grievance Committee and the Committee on Ethics.

V. W. SPICKARD, M.D., *Chairman*
Committee on Revision of the
Constitution and By-Laws

(The Resolutions Committee recommended that the above amendment "do not pass," and it was defeated.)

Resolutions

Department of Labor and Industries Fee Schedule

WHEREAS, The State Department of Labor and Industries has, without proper consultation with any committee representing the Washington State Medical Association and in a dictatorial manner, compiled a new fee schedule that is very inadequate from the standpoint of listings and, also, from the standpoint of fee allowed;

THEREFORE, BE IT RESOLVED, The Board of Trustees of the Washington State Medical Association obtain the advice of counsel and direct whatever action seems necessary to obtain a reasonable fee schedule from the Department of Labor and Industries, and also advise the members of this Association what action they can take as individuals.

ALFRED O. ADAMS, M.D., *Member*
House of Delegates

(Substitute Resolutions were introduced for the above resolution, upon which no action was taken.)

Department of Labor and Industries Fee Schedule

RESOLVED that this Association submit to the Department of Labor and Industries the Over-All Fee Schedule of this Association as an acceptable fee schedule for the care of the injured workman, and be it further

RESOLVED that a copy of this resolution be submitted to the Department of Labor and Industries and to the headquarters of all labor organizations within the State of Washington.

R. D. REEKIE, M.D., *President*
Spokane County Medical Society

(Upon recommendation of the Resolutions Committee the above resolution, briefed for publication purposes, was disapproved.)

Substitute Resolution

Department of Labor and Industries Fee Schedule

WHEREAS, The director of the State Department of Labor and Industries has recently issued new medical aid rules and fee schedules, effective August 15, 1951, that are improper and inadequate in many respects; and

WHEREAS, The rules and fee schedules were issued without adequate consultation with duly appointed representatives from the Washington State Medical Association and in disregard of the recommendations of said representatives; and

WHEREAS, A survey of the membership of the Washington State Medical Association has elicited a response from those who treat a considerable number of industrial cases showing that a substantial majority is dissatisfied with these rules and fee schedules;

THEREFORE, BE IT RESOLVED, That Governor Arthur B. Langlie and Mr. A. M. Johnson, Director of the Department of Labor and Industries, be notified that the members of the House of Delegates of the Washington State Medical Association disapprove certain portions of the rules and fee schedules and also disapprove the manner in which they were drawn up and request that the Director reconsider said rules and regulations and seek consultation with the duly authorized representatives of the Association.

ALFRED O. ADAMS, M.D., *Member*
House of Delegates

(The above substitute resolution was adopted.)

Substitute Resolution

Department of Labor and Industries Fee Schedule

WHEREAS, The director of the State Department of Labor and Industries has compiled and issued new medical aid rules and maximum fee schedules, effective August 15, 1951, without adequate consultation with duly authorized representatives from the Washington State Medical Association and in disregard

Season's Greetings

This being Seattle's Centennial Christmas, the Metropolitan Building Company is happy to salute the medical profession for its important contribution to the development of this area throughout the years.

We are proud also to have had a part in this progress, through the facilities and services provided in our medical and dental properties . . . the Medical and Dental, Cobb and Stimson Buildings in Seattle.

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of the recommendations of said representatives, which rules and schedules are improper and are inadequate from the standpoint of the reasonableness of the rules and of listings and also from the standpoint of many of the fees prescribed;

THEREFORE, BE IT RESOLVED, That the Board of Trustees of the Washington State Medical Association initiate an appeal from the action taken by the Director of the Department of Labor and Industries in regard to these Rules and Fee Schedules.

ALFRED O. ADAMS, M.D., *Member
House of Delegates*

(The above substitute resolution was adopted.)

Resolution

Hospital Medical Staff Meetings

WHEREAS, it is believed that the disturbingly small attendance at County Medical Society meetings is due in large part to the large number of other meetings which the Society members are required to attend,

BE IT RESOLVED, That the Washington State Medical Association strongly recommends that all hospitals in the State of Washington take steps to reduce the number of their staff meetings to four per year. *Or in smaller communities at the discretion of the staff members.*

DAVID METHENY, M.D., *President
King County Medical Society*
CLARK C. GOSS, M.D., *President-elect
King County Medical Society*

(Above resolution was approved as amended. Italic matter indicates amendment.)

Insurance Reports

BE IT RESOLVED that this Society recommend to the House of Delegates of the Washington State Medical Association, for favorable action, that a uniform state-wide rule be adopted approving a nominal charge by medical practitioners for the completion by them of insurance reports and questionnaires respecting the physical condition of patients.

HOMER FRANK, M.D., *Secretary
Thurston-Mason County
Medical Society*

(Upon recommendation of the Resolutions Committee, the above resolution was disapproved.)

House of Delegates

Second Session

Wednesday, September 12, 2:30 p. m.

The Speaker called the Second Session of the House of Delegates to order at 2:30 p. m., Wednesday, September 12, 1951, in the Olympic Bowl, Olympic Hotel, Seattle. Roll call showed a quorum present.

Dr. Clarence A. Smith, 91, Editor Emeritus of NORTHWEST MEDICINE, was introduced to the House of Delegates and was given a well-deserved ovation.

The following members of the Press were introduced: Messrs. John Bigelow, Science Editor of the *Seattle Times*, Jim Huff and Fergus Hoffman of the *Seattle Post-Intelligencer*. Through their cooperation the 1951 annual meeting received excellent publicity, and appreciation was expressed.

Woman's Auxiliary Annual Report

Mrs. Raymond M. Schulte, president, Woman's Auxiliary, presented her report to the House of Delegates and it was duly accepted.

As we come to the close of another Auxiliary year it is well to stop and evaluate what has been accomplished.

We have not grown greatly in numbers during this year, but we have not lost in membership either. We have an Auxiliary in each county with more than

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ten men in the Medical Society, with one exception, Whitman County. So there is little opportunity to increase the number of County Auxiliaries. We have either failed to make the doctors' wives or the doctors themselves in that county understand the possibilities for helpfulness in organization. Some of them fail to understand the great opportunity to work shoulder to shoulder with their husbands in this fight for the American way in the practice of medicine. We are hoping for better success with them in the immediate future.

Our members-at-large have been a help during the year and we hope that before too long every doctor's wife in the state will take her place either in a county auxiliary or as a member-at-large. If any of them feel unable to give the time and energy to the program, perhaps they will pay their dues so that those who are able to give time may use their dollars to promote the work which is requested of us by the American Medical Association and the Washington State Medical Association.

Through informed members the program is carried to the laymen. Our members are leaders in every other organization in the State of Washington. During the last two years we have stressed that they be active in A. A. U. W. and P.-T. A. especially.

Our legislative chairman, Mrs. Campbell of Olympia, has kept in touch with the Executive Secretary of the Medical Association and the county Legislative Chairmen, putting pressure at strategic points at the proper time. Both Mrs. Campbell and I have attended the sessions of the legislature and also watched carefully the action of the National Congress. She has started many a telegram on its way, when pressure looked advisable. At election time we have tried to see that work was done for those candidates who are friendly to medicine. Personally, I spoke before more than thirty lay groups immediately before election day. Some of our groups worked to see that people were registered and several provided transportation to the polls on election day.

We have tried to impress our medical families with their opportunity to show strength through votes. A spot check in an average county showed that 18 per cent of the doctors and 22 per cent of their wives failed to vote in the last election. I am sure this would not hold true in the State of Washington. The A. M. A. has urged that every doctor and his wife become politics-conscious and not only vote for but work for good candidates.

In our state we have more than twelve hundred members and nationally there are more than fifty-seven thousand of us.

At the Atlantic City meeting the National Auxiliary contributed \$10,000.00 to the educational fund of the A. M. A. and \$500.00 to Careers for Nursing as well as \$100.00 to the World Medical Association.

Our State Auxiliary has given more than fifteen hundred dollars in nurses' scholarships and \$2,206.00

for other philanthropies. Spokane County is training volunteers from its group to draw and type blood for the Blood Bank in case of emergency. The Thurston-Mason Counties Auxiliary did a nice piece of Public Relations in giving a tea for the women legislators and the wives of the men legislators. Practically every county has done something outstanding in Public Relations under the direction of Mrs. Qualheim, the Public Relations Chairman. King County is doing radio broadcasts which must surely bear fruit. It is not possible for me to mention the job done by every county.

Dr. Elmer Henderson, the immediate past president of the A. M. A., said of us, "By their splendid efforts in this important work Women's Auxiliaries throughout the country are earning new gratitude and new appreciation of their Medical Associations. They are gearing their activities smoothly into local campaign patterns and the result is a well-coordinated informative program to carry the truth to the public." Dr. Borzell, the speaker of the House of Delegates of the A. M. A., said, "If there ever has been any doubt as to the need or usefulness of the Woman's Auxiliary to the A. M. A. it has been completely dispelled in the last few years."

The Presidency is a job which I have not carried alone. Every member of the Board and every county organization has given cooperation for which I am grateful. Under the chairmanship of Mrs. Wayne Lockwood we rated second in the nation in subscriptions for "Today's Health." Through a technicality we did not receive the prize money, but the work was done. We urge every doctor to cooperate with the Auxiliary by buying this magazine on health. Published by the M.D.'s

I attended the National Convention in Atlantic City, last June, and served as parliamentarian, and as a member of the Resolutions Committee and the Reading Committee. This was recognition, not of me, but for the State of Washington.

It has been a joy to have the president-elect, Mrs. Albert Bowles, work with me during the year. She has made many friends over the state who will be working with her this next year. My appreciation goes to the office of the Washington State Medical Association and to Mr. Neill, who has been most cooperative; to the State officers and chairmen and to every county Auxiliary for the help which has made this a good year for your Auxiliary. The pleasure of having served as its president is a great one, one which will be with me always.

MRS. RAYMOND SCHULTE, *President*
Woman's Auxiliary

Necrology Committee Report

Dr. Austin G. Friend, chairman, read the report of the Necrology Committee and requested that all stand for a moment of silence in memory of former members who have departed:

Necrology 1951

- Anderson, F. W., South Bend, age 72. Died Nov. 20, 1950.
 Battle, J. F., Seattle, age 59. Died July 27, 1951.
 Beatty, John, Snohomish, age 61. Died Dec. 15, 1950.
 Bice, Delmar F., Yakima, age 68. Died May 23, 1951.
 *Cerswell, B. S., Yakima, age 77. Died June 23, 1951.
 Collins, Isaac, Spokane. Died Nov. 2, 1950.
 *Dixon, C. L., Seattle, age 80. Died Sept. 23, 1950.
 Douglas, T. E., Seattle, age 61. Died July 19, 1951.
 Farrow, Joseph, Spokane, age 86. Died Aug. 16, 1951.
 Fretz, Lewis J., Seattle, age 51. Died Sept. 22, 1950.
 Gibson, J. F., Olympia, age 71. Died April 2, 1951.
 *Grove, C. E., Spokane, age 88. Died July 10, 1951.
 Hamblin, Robert N., Spokane, age 66. Died March 18, 1951.
 Hartin, David, Spokane, age 60. Died March 19, 1951.
 *Hendricks, Ralph, Spokane, age 77. Died Nov. 19, 1950.
 Hiltner, W. G., Seattle, age 51. Died July 29, 1951.
 Hutchinson, J. L., Seattle, age 79. Died May 20, 1951.
 Johnson, P. S., Yakima, age 49. Died Oct. 3, 1950.
 Kaveney, I. E., Port Angeles, age 47. Died Jan. 20, 1951.
 *Klempner, Louis, Seattle, age 85. Died Dec. 7, 1950.
 *Knudtson, Albert, Seattle, age 74. Died Jan. 8, 1951.
 Lieser, Ralph, Vancouver, age 60. Died Aug. 15, 1950.
 Loudon, John P., Yakima, age 68. Died Feb. 18, 1951.
 O'Shea, John H., Spokane, age 68. Died July 18, 1951.
 *Peacock, Alex., Seattle, age 71. Died April 13, 1951.
 Phillips, B. L., Clarkston, age 72. Died Oct., 1950.
 Price, George E., Seattle, age 77. Died April 14, 1951.
 Schori, John W., Seattle, age 50. Died Dec. 7, 1950.
 Stusser, Samuel, Seattle, age 51. Died Aug. 6, 1951.
 *West, Edmund S., Yakima, age 71. Died Dec., 1950.

*Honorary

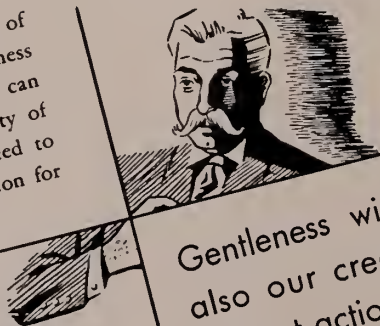
Committee on Place of 1953 Meeting

Dr. Asa Seeds, chairman, stated the Committee recommends the 1953 meeting of the Association be held at the Olympic Hotel, Seattle, beginning on the afternoon of the second Sunday of September. The recommendation was adopted.

Election of Officers

The following report of the Nominating Committee, which was regularly reported to each member of the House of Delegates, thirty days prior to this Session, was presented:

DANIEL DEFOE (1661-1731) gave this bit of wise advice: "Try all methods of gentleness and patience which a forbearing temper can dictate or which prudence and the safety of his debt will allow, before you proceed to prosecution. Proceed with all due caution for the reputation of the debtor."



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NOMINATIONS

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President-Elect, Ralph Loe, Seattle
Vice-President, A. E. Lien, Spokane
Secretary-Treasurer, Bruce Zimmerman, Seattle
Asst. Secretary-Treasurer, William McMahon, Seattle
Speaker of the House, M. Shelby Jared, Seattle

TRUSTEES

Eastern District (two-year term), H. F. Brundage, Yakima; A. A. Yengling, Walla Walla.
Western District (two-year term), W. W. Ebeling, Mount Vernon; H. D. Fritz, Cathlamet.

Trustees-at-Large (two-year term), John Hardy, Endicott; Harold Gunderson, Everett; Jack Freund, Kennewick; Bernard Harrington, Tacoma; B. N. Collier, Shelton, and Frank Wanamaker, Seattle.

A. M. A. Delegate (To take office January 1, 1952, for two-year term), A. O. Adams, Spokane; R. L. Rotchford, Spokane, alternate.

Finance Committee (three-year term), Homer Humiston, Tacoma.

(These names were regularly placed in nomination.) The Speaker then stated that any nominee wishing to withdraw must do so from the floor and declared other nominations open.

President-Elect, Dr. Ralph Loe, of Seattle, withdrew his name from nomination and nominated Dr. C. E. Watts, Seattle, who was elected.

Vice-President, Doctor Calhoun nominated Dr. I. C. Munger, Vancouver. Doctor Munger was declared elected.

Secretary-Treasurer, Dr. Bruce Zimmerman, Seattle, was elected.

Asst. Secretary-Treasurer, Dr. William A. McMahon, Seattle, was elected.

Speaker of the House, Dr. M. Shelby Jared, Seattle, was elected.

Two Trustees, Eastern District (two-year terms), Drs. Maurice Bryant, Colfax; William L. Ross, Yakima; and A. O. Adams, Spokane, were nominated. Doctors Ross and Adams were declared elected.

Two Trustees, Western District (two-year terms), Doctors W. C. Moren, Bellingham; Quentin Kintner, Port Angeles; and Emmett L. Calhoun, Aberdeen, were nominated, and Doctors Kintner and Calhoun were declared elected.

Six Trustees-at-Large (one-year term), Drs. W. C. Moren, Bellingham; A. A. Yengling, Walla Walla; David Metheny, Seattle, were nominated, and Doctors Jack Freund, Kennewick; John L. Hardy, Endicott; Frank Wanamaker, Seattle; David Metheny, Seattle; Bernard Harrington, Tacoma, and W. C. Moren, Bellingham, were declared elected.

A. M. A. Delegate (two-year term commencing January 1, 1952), Doctor Ludwick nominated Dr. A. G. Young, Wenatchee. Doctor Young was declared elected.

A. M. A. Alternate, Doctor Freund nominated Dr. Frederick C. Harvey, Spokane, and Doctor Harvey was declared elected.

Finance Committee (three-year term), Dr. Homer Humiston, Tacoma, was elected.

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UNFINISHED OR NEW BUSINESS

Department of Labor and Industries

Doctor Adams moved, it was seconded and carried that: "The Board of Trustees advise the members of this Association of their individual legal rights in dealing with the Department of Labor and Industries.

Department of Labor and Industries

Doctor Adams moved, it was seconded and carried that: "The Board of Trustees investigate the advisability of sponsoring a change in the present State Industrial Laws to provide for optional insurance in this State and report findings to this body at its next annual or special meeting."

Medical Director, Labor and Industries

Dr. John Culp, Seattle, moved, it was seconded and carried that: "The Board of Trustees explore the possibility of recommending to the Department of Labor and Industries a full-time medical director."

Selective Service

Doctor Adams spoke on the work of the Advisory Committee to the Selective Service on the Selection of Doctors, Dentists and Allied Specialists. "It acts as a liaison between the draftee and the draft boards and determines essentiality on the basis of the medical and health needs of the community, critical research and professional teaching. It also determines whether an extreme hardship might result to the draftee (other than a financial one)." He outlined the categories set up, stating that call-ups in the different categories are nationwide. "The bottom of

the Category I barrel is being scraped," he said. "It is doubtful men in Categories III and IV will be called in the near future unless the situation changes. A number of men in Category I have accepted commissions but have not been called, whereas Draft Boards are drafting men in this category who have not accepted reserve commissions. There have been a limited number of deferments in the State."

Officers Commended

Doctor Gaiser moved, it was seconded and unanimously carried that: "The House of Delegates give Doctor Partlow a vote of thanks for the quiet, unobtrusive manner in which he had efficiently run the affairs of the Association during his term of office."

It was moved, seconded and unanimously carried that: "The House of Delegates express thanks to Doctor James H. Haviland for his unremitting efforts

as Secretary-Treasurer during his three-year term of office. His job performance has been of the highest caliber."

Induction of New President

Doctor Partlow escorted the new President, Dr. Reuben A. Benson, to the rostrum for induction ceremonies. Doctor Benson said: "... in all honesty and sincerity I must tell you this is a proud day for me. I am mindful of the honor you have done me and hope to be given the strength and the courage to fill this position with the dignity and honor vested in it. I pledge to do the best I can."

There being no further business, the Sixty-second Annual Session of the House of Delegates of the Washington State Medical Association, held at the Olympic Hotel, Seattle, September 9-12, 1951, adjourned at 7:00 p. m.

Partlow Warns Physicians Against Socialism, Disunity, "Local Autonomy" and Complacency—Wants Action

Presidential Address September 11, 1951

By K. L. PARTLOW, M.D.

Gentlemen:

It is not my purpose here to report in any detail on the events and accomplishments of the year of my presidency. This information is adequately covered in reports to the House of Delegates by the Board of Trustees, the Executive Committee and the various other committees. Rather, I would prefer to speak on some of the many things that have impressed me during my tenure of office.

The duties of your president were not as heavy as it might first appear. Although a considerable time is consumed in minor details, our executive secretary, Mr. Ralph Neill, has a faculty of arranging things so as to save the president much time and effort. I have watched him through several sessions of the State Legislature, and his faculty for carrying through our program is well known to all of you. Time does not seem to be a factor with him, as I learned the hard way. He does not hesitate to call at two or three o'clock in the morning when some important move is a-foot, or matters of importance are pending. This habit of his caused him to be known to our opposition, during the past session of the Legislature, as "Paul Revere."

There was a time in our lives when doctors were thought to be a group of well-educated, well-meaning individuals, pursuing their various activities with energy and some success, but who had little influence in that great factor of our national economy called politics.

Some twenty years ago, certain politicians decided that what we stand for and do could be used both

for their political and personal gain. It was their opinion, that if we, a minority group, could be put under their domination, then the domination of the American people as a whole would simply be a matter of the passage of time.

Over this period of time we have seen ourselves pushed along the road of Socialism. We have seen our savings being confiscated and squandered, our money devaluated, a huge national debt created.

For many years, we have seen our personal liberties curtailed. For twenty years we have seen the New Deal, then the Fair Deal force us to take opiates in the form of hand-outs to dull our resistance to becoming slaves of the state.

We, a minority group, with one thing only to sell, our services, have found ourselves classed as tradesmen violating the Sherman Anti-trust law.

We have found ourselves unable through our Association to engage in politics, although more powerful service organizations can do so legally, and even with encouragement by certain politicians. We, in this state, were requested by an official representative of Congress, to explain our actions in the last election campaign, and he was from a state other than Washington.

We, a minority group, have seen a member of our profession dismissed as surgeon general of the United States Public Health Service, because he refused to be a "yes man," even though his professional record was above reproach. This could possibly be an attempt to test public reaction before applying this same "yard-stick" to the military.

We, a minority group, have seen a socialized medicine bill introduced before Congress which violated three sections of the United States Constitution.

We, a trade organization, have found ourselves unable to build up a fund for retirement, although other similar organizations have been able to do so. An attempt is being made by the A.M.A. to correct this deficiency, and your Association has assisted in this effort.

Upon us, as physicians, have been imposed responsibilities over and above those which most Americans must assume, because our Armed Forces must be provided with adequate medical care of the highest quality. Doctors are needed not only for those fighting in Korea, but also for the expanding military forces deemed necessary for national safety. In addition, the profession must carry a large share of responsibility for creating an adequate civil defense program.

For the first two requirements, the government is drafting medical men up to the age of 45, while the older men will be left home to care for the civil defense program.

All these requirements, and more, are being met by the medical profession to the best of its ability. At the same time, medical services to the people are being improved and increased at a pace not equalled elsewhere in the world, either in these times or during previous periods. The records speak for themselves and we should be ever alert to permit no one to gloss them over with a cloudy veneer, or to tear them down by half-truths and innuendo.

Although I have been fortunate in finding many of my colleagues who were ready to assist us in our State Association business, there still are too many in the profession who find themselves too busy or otherwise occupied to serve on committees and take an active part in Association business. But, all of us will certainly pause long enough to watch and lament, if and when our profession is engulfed by a government bureau. If the medical profession is to remain free from the grasp of those who see personal gain in its control, we all must accept our responsibilities as we see them, and as they are thrust upon us.

At present, we are in a lull before another storm. Our opposition has been blocked through our public relations activities from forcing socialized medicine upon us by frontal attacks and he is now trying to out-flank us, as evidenced by the offer of hospitalization to the aged. As the A.M.A. so ably stated, "This legislation is proposed to create a new issue for Fair Deal candidates during the coming elections and is an effort to provide them with an escape hatch so they can avoid going before the people on the direct issue of compulsory health insurance."

Again, I say, we, individually and collectively, must be ever alert or be subject to capture and enslavement while in repose.

The Little Man from Missouri, conscious of straws in the political winds, recently admitted he was not entirely sold on state medicine, but would accept anything, as long as it is as good, or nearly as good as state medicine. His statement went so far as to include such a program, even if offered by the medical profession. Now, what have we done about that in Washington State?

It is widely admitted among the profession that our voluntary prepaid medical plans far exceed in possibilities, at least, any program offered by the socializers. We, in Washington State, were pioneers in that plan, but at this stage of the game we are in a state of confusion. We have twenty-three medical service bureaus, each a separate corporation, writing twenty-two separate and distinct contracts. The people are NOT looking for mediocrity, but they *are* looking for uniformity. Confusion is created by "local autonomy" which prevents cooperation and an over-all sense of common direction and effort.

I know of nothing that is more disrupting to our programs on a state-wide basis than "local autonomy," when it is abused. State-wide problems are always vexing, but when faced with the added burden of misused "local autonomy," solution of these problems then becomes almost impossible. There seems to be no coordinating influence. In far too many cases, each bureau goes blithely down its own path, with little or no thought of the problems as a whole. Thus, accomplishment is retarded, business is lost to the bureaus, and service to the public, which should be of first consideration, suffers. "Local autonomy" worked to our disadvantage in considering the program under Initiative 178. Again it was the stumbling block when the State Bureau attempted to write a contract with the populous Teamsters' union. One influential bureau said "no" and the contract was lost. There is no stimulus to progress under such circumstances. We must readjust our thinking. Selfishness must be set aside and

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cooperative efforts must be substituted, or we will get no place in fulfilling our ambition of providing the type of medical services to the public that will obliterate any thought on the part of a propaganda-fed people that socialized medicine is good for them.

And the difficulties just stated are greatly magnified by factional fights within our own group. More of our membership should acquaint themselves with our problems on the state-wide level, and our difficulties would be more apt to end in greater accomplishments.

Several years ago, our State Bureau was brought to Seattle in order that closer cooperation might exist between that bureau and the State Association. This proved to be a distinct advantage, especially when the two organizations were housed in the same offices. Not long ago, the bureau, in the belief it had outgrown its quarters, moved into another building. Thus, the "family" was broken up and dispersed again. Personally, I think the bureau should have stayed where it was until something more advantageous could be worked out.

It has long been the opinion of officers of the State Association that it and allied organizations should be housed together, so that their activities could be better coordinated. The Executive Committee, with consent of the Board of Trustees, has considered this matter from various viewpoints, its final conclusion being that an attempt should be made to accomplish that goal. Accordingly, a study

is being made in the hopes that a building can be constructed, leased or otherwise acquired, where the Association, the State Bureau, NORTHWEST MEDICINE, King County Society and Bureau, and other allied groups could be quartered together, in order that our efforts might be more fruitful.

Action along this line would have been further advanced, but for war scares, the Korean situation, unavailability of materials and for other reasons. The study will continue, I hope, to the end that in the near future definite developments will permit us to realize our ambitions.

There are many other activities and plans still in the formative stages and which will have close attention under the new regime. We are fortunate in having continuity in membership of the Board of Trustees and the Executive Committee, and there is little delay occasioned in our operations by the annual change in administration. Thus, progress will continue.

It has been a pleasure and a privilege to serve you during my term as president. I am deeply appreciative of the efforts extended by our many committees and by many of my colleagues personally. I know further strides will be made under our new president, Dr. Benson, and I wish to assure you and him that I stand ready and willing to be of service at any time. Thank you for this opportunity of expressing my views.

Medical Notes

Our special feature, Medical Economics News, will not appear in this issue as its author, Ralph Neill, executive secretary of Washington State Medical Association, is in the hospital recuperating from an operation.

Erratum

The November issue of NORTHWEST MEDICINE published an erroneous statement concerning K. K. Sherwood. It was stated that Dr. Sherwood "... superintendent of Georgetown Branch, King County Hospital, participated in a panel ..." This was in error.

The superintendent of King County Hospital is Edwin S. Bennett. Dr. Sherwood is Chief of Professional Services of the Georgetown Branch of King County Hospital.

Society Meetings

WALLA WALLA VALLEY. October meeting of the Walla Walla Valley Medical Society was held at the Grand Hotel, Walla Walla, October 11. Principal speaker was Gordon W. McGowan, Pendleton, Ore., who presented a paper on Some of the Complications of Obstetrics.

Roger Anderson, Seattle, was guest speaker at the November 8 meeting of the society. His subject was Practical Method of Diagnosis and Treatment of Backache.

COWLITZ COUNTY. First fall meeting of Cowlitz County Medical Society was held at Hotel Monticello, Longview, September 19. Charles Wilson, cardiologist, Portland, Ore., gave a talk on successful treatment of thyroid disorders by radio-active iodine.

Earl Pearce, pediatrician, was admitted to membership in the society. John Nelson reported on the meeting of the House of Delegates at the State Medical Association Convention.

Second fall meeting, held at the same location, October 17, was highlighted by a moose feed furnished by Dewey Fritz, Cathlamet. Dr. Fritz had just returned from a very successful moose hunt in Canada.

Ed Van Aelstyn, Vancouver, Wash., presented a comprehensive report on the proposed mass chest x-rays to take place in Cowlitz, Clark, Skamania and Wahkiakum counties beginning November 15 in which three x-ray units were to take part.

*We wish our many friends
of the
WASHINGTON STATE MEDICAL ASSOCIATION
and Component Societies
a
very Merry Christmas and
Successful New Year*

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Season's Greetings

This is the twentieth year we have sent best wishes to our many friends throughout the Northwest.

Many changes have taken place since Christmas, 1931 . . . changes which include our own modern building at Eighth and Olive and many added services.

But we are happiest of all about the many new friends we have made . . . adding more each succeeding year.

To all our friends—we wish you the very best during the coming year.

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E. Victor Simison, M.D., Pocatello

Medical Notes

George E. Brown, Jr., Twin Falls, a member of association's Civilian Defense Committee, represented Idaho at National Civilian Defense Conference called by the A.M.A., American Hospital Association and State and Territorial Health Officers in Chicago, November 9-10.

State Association's Civilian Defense Committee will meet in Boise following this meeting, Chairman Verne J. Reynolds reports.

State Hospitals Board, formerly the Charitable Institutions Commission, has issued the following order regarding Designated Examiners under the new Commitment Law:

"All physicians and surgeons licensed to practice in the State of Idaho, and/or all physicians and surgeons employed by the State Hospitals Board, are hereby designated as "Designated Examiners" for the purposes of Chapter 290, 1951, Session Laws of Idaho."

New officers elected for the coming year for the Southwestern Idaho District Medical Society, are as follows: John J. Kaiser, Payette, president; Norman Hedemark, Boise, vice-president; Richard A. Forney, Boise, secretary, and George E. Weick, Boise, treasurer.

Robert S. McKean, association secretary-treasurer, has been appointed chairman of the Governor's Committee for the Study of Children and Youth. This committee replaces the State Whitehouse Committee.

Dr. Leoman Dustin Huff, 67, Fruitland, died October 26. Born on February 28, 1884, in Hedrick, Iowa, Dr. Huff was a graduate of Drake University Medical School and practiced in Des Moines and Wichita, Kans., before coming to Idaho in 1944. He had also practiced in Payette and Nampa.

New honor to President Alfred M. Popma. During annual meeting of the American Cancer Society in New York, Dr. Popma was elected a vice-president of the organization. Dr. Popma recently completed

serving his third two-year term as a member of the national board of directors of the ACS from the Northwest region.

The Governor's Polio Planning Committee reports that, because of lack of funds available through the National Foundation for Infantile Paralysis, a special committee made up of three physicians was appointed to study and evaluate polio convalescent cases currently being cared for as well as future cases.

The committee, consisting of Frank L. Fletcher, chairman; Manley B. Shaw and Fred O. Graeber of the State Public Health Department, made the following report concerning the long-term care of convalescent polio patients: 1. That one year be made a limit for the care of any patient after the acute phases of the disease have subsided. 2. That a general policy based on the following criteria be set up:

A. Children under three years of age who show no improvement in three months be sent home and returned for re-evaluation three months later.

B. That Categories of classifications be set up for the patient as follows: (a) Respirator patients. (b) Bed patients requiring complete care. (c) Bed patients who can feed and partially care for themselves. (d) Wheel chair patients. (e) Patients who are ambulatory with or without appliances. (f) Patients who are self-sufficient and will eventually become self-supporting.

C. Except under unusual circumstances, a patient must progress from one category to a more advanced one in a three-month period to justify further training and rehabilitation.

E. That the Orthopedist, Pediatrician and Physio-Therapist in attendance be requested to submit evidence to justify further care of those patients who have been on the poliomyelitis program for one year and that the committee review these with a view to their discharge and permanent care, where indicated, elsewhere.

Third semi-annual meeting of Boise Valley Chapter of American College of Surgeons will be held in Boise December 1, according to F. B. Jeppesen, Boise, secretary. Southern Idaho and Eastern Oregon physicians and surgeons are being invited to attend the conference, which will be held at the Owyhee Hotel.

Scientific papers will be presented by Bruce C. Budge, Howard M. Chaloupka, Norman Hedemark, Quentin W. Mack, Verne J. Reynolds, all of Boise, and J. L. Montgomery, Caldwell.

Herbert L. Hartley, Seattle, editor of *NORTHWEST MEDICINE*, will also address the group.

Principal speaker at a dinner meeting of the chapter will be Louis P. Gambee, Portland, associate clin-

ical professor of surgery at the University of Oregon Medical School. Dr. Gambee will also participate in discussions of each scientific paper presented.

A. C. Jones, Governor of Idaho for American College of Surgeons, will present a charter to Boise Valley Chapter. Everett Jones of Boise is president of the chapter, which has the distinction of being the fourth such group organized in the United States.

State Board of Medicine

Four temporary licenses were issued during October. Applying for and receiving these were:

Roy Davis Sinclair, Salmon. Graduate of University of Nebraska College of Medicine, 1931, Omaha. General practice.

Wilbur L. Waterman, Caldwell. Graduate of Johns Hopkins University School of Medicine, 1948, Baltimore. Pediatrics.

W. W. Rennings, Salmon. Graduate College of Medical Evangelists, Loma Linda, 1950, Los Angeles. General practice.

Alfred Thomas DeVito, Moscow. Graduate of Hahnemann Medical College, 1944, Philadelphia. Pediatrics.

Next regular meeting of State Board of Medicine will be held in Boise, January 7-9, 1952, for the purpose of granting licenses without examination as well as by written examination. Candidates are requested to file their applications by December 7, 1951.

RETURN FROM SERVICE: From Navy Duty—Mark R. Baum, to practice dermatology in Idaho Falls, and James C. F. Chapman, to practice obstetrics and gynecology in Boise. From Air Corps—Quentin E. Howard, to practice general medicine in Emmett.

North Idaho District Medical Society met at the Bollinger Hotel, Lewiston, October 17.

The Committee on Honorary Membership presented a proposed change in the Constitution. It was moved and seconded that Article 1, Section 5, Paragraph C be changed to include "... with all dues remitted, if he so requests by a written application to the Society."

Scientific portion of the meeting consisted of a paper presented by Joseph H. Crampton, Mason Clinic, Seattle. His subject was Diabetes and Its Control With the Newer Insulins.

ALASKA TERRITORIAL MEDICAL ASSOCIATION

President, H. Romig, M.D., Anchorage



ANNUAL MEETING Anchorage, June, 1952

Secretary, W. P. Blanton, M.D., Juneau

Medical Notes

ALASKA PHYSICIANS ATTEND REFRESHER COURSE. Nine physicians from Alaska attended the cancer refresher course held at University of Oregon Medical School, September 24-28. Representing all sections of Alaska, they were: William P. Blanton, Juneau; Ralph Carr, Ketchikan; C. C. Carter, Juneau; Hugh Fate, Fairbanks; George E. Hale, Milton Kepler and Peter Koeniger, Anchorage; John Libby, Dillingham, and John B. Porter, Cordova.

Other states represented at the refresher course were Oregon, Idaho and Montana. The class had a total enrollment of 80 physicians.

The Alaska delegation extends its thanks to Frank Queen, University of Oregon Medical School, in appreciation for his work in arranging and developing this worthwhile course.

CHANGE IN PLANS. Annual meeting of Alaska Territorial Medical Association for 1952 will be held at McKinley Park instead of Anchorage, as formerly

announced. This change was necessary due to crowded conditions and difficulty of obtaining hotel space. Actual dates will be set later but tentative plans are to hold the convention in August instead of having a spring meeting.

Locations

Merritt P. Starr, formerly of Seattle, is now practicing at Anchorage.

Edward J. Ridenour, Fairbanks, is another new arrival to the Territory.

William Orr and Joseph H. Shelton have recently left Seward to practice in the States.

Francis J. Phillips, chest surgeon at Seward Sanatorium, Bartlett, has been licensed to practice in the Territory.

Hazel I. Blair, Anchorage, is attending a postgraduate course at Cook County Graduate School of Medicine, Chicago, Ill.

MISCELLANY

Farwest Leads Nation in Service-Type Medical Care Plans

The Western United States has by far surpassed the east and mid-west in development and operation of service-type prepaid medical care plans, with the Pacific Northwest leading the entire nation in this field. Mr. George W. Cooley of the Council on Medical Service of the American Medical Association told the more than 100 physicians and bureau managers attending the annual meeting of the Western Conference of Prepaid Medical Care Plans in Seattle, November 9-10.

Cooley said this area not only pioneered prepaid care but has been a national leader in developing it to the point where it provides an amount of care unsurpassed anywhere in the country and at the same time protects the best interests of the physicians.

A. O. Pitman of Hillsboro, Oregon, was elected chairman of the Western Conference for the coming year, succeeding Ray T. Woolsey, of Salt Lake City. G. L. Watson, of Vancouver, B. C., was re-elected secretary. At the invitation of A. M. Popma, of Boise, Idaho, the delegates voted to hold the next meeting of the Conference in Boise.

Most of the sessions on the first day of the conference were devoted to analysis of the practical administrative experiences and problems encountered throughout the year by the various Western United States and Canadian Plans.

Of special interest to the delegates was the account given by E. C. McCoy, of Vancouver, B. C., of the

establishment this year of Trans-Canada Medical Services to serve as the co-ordinating agencies for all the plans operating in the various Canadian provinces. Dr. McCoy is treasurer of the Trans-Canada Medical Service Commission.

Physician delegates representing the various areas in the discussions included Pitman, McCoy, Popma, James McCabe of Helena, Montana, and Wendell Knudson of the King County Medical Service Corporation of Seattle.

Indication of what the future holds for the prepaid plans in the West was given by Mr. George LaFray, general manager of the King County Medical Service Corporation, and Mr. Harry House, general manager of the Pierce County Industrial Medical Bureau of Tacoma. Both emphasized a need for strengthening and broadening the care offered, for greater interest and participation in these plans by physicians as a whole and for the plans to be able to offer a "one-package" plan, including health care and insurance, through which they can compete for employer-paid, union-negotiated coverage.

R. A. Benson, of Bremerton, president of the Washington State Medical Association, was the speaker at the Conference banquet. He pointed out the medical profession fully endorses the prepaid plans but emphasized that the individual doctor occasionally needs a re-affirmation in the basic faith and philosophy that goes into prepaid medicine.



Officials of Western Conference of Prepaid Medical Service Plans. Left, Dr. R. T. Woolsey, Chairman, and Dr. G. L. Watson, Secretary.

Wives of Delegates Entertained

Luncheon in the Georgian Room at the Olympic Hotel for the wives of delegates was hosted by Washington State Medical Association. On the entertainment committee were the Mesdames John Steen, George LaFray, M. Shelby Jared and Ralph Neill. Those attending the conference from Vancouver, B. C., included the Mesdames Wallace J. Dorrance, A. L. McLellan, G. L. Watson, H. W. Jones and Haakon



Conference Speakers. Left, Dr. A. G. Young, Wenatchee, and Dr. R. A. Benson, Bremerton.

Soros. Others were the Mesdames D. K. Worden, Lewiston, Idaho; H. M. O'Braun, Pocatello, Idaho; A. O. Pitman, Hillsboro, Ore.; S. M. Cowan and Ed. Matoon, Yakima, Wash.; L. A. Campbell and Max Clark, Olympia, Wash.; Harold Brown, Wenatchee, Wash.; Walt Mercer, Mt. Vernon, Wash.; Charles Riddell, Jeff Warren and James Barron, all of Seattle.

After luncheon the ladies were taken on a tour of Northgate and were entertained there at a tea given by King County Medical Bureau.



The Canadian Delegation. Front row, l. to r.: Mrs. Dorrance, Mrs. McLellan, Mr. McLellan, Dr. Dorrance, Mr. H. Soros. Back row, l. to r.: Dr. Watson, Mrs. Watson, Dr. Alexander, Mrs. Soros, Mrs. Jones, Dr. McCoy, Mr. Robinson, Mr. H. W. Jones.

McCoy Outlines Canada Medical Service Plan

An enthusiastic delegation from Canada participated in the Western Conference of Prepaid Medical Service Plans held in Seattle, November 9-10. Featured speaker at the conference was E. C. McCoy, Vancouver, B. C., physician, who pointed out the similarity of interests in the medical service plans of the United States and Canada.

Activities of provincially incorporated plans are correlated by an unincorporated body representative called Trans-Canada Medical Services, Dr. McCoy said. The organization was formed this year to coordinate the needs, facilities, resources and practices of the respective areas with the health and welfare of the public.

"In June representatives of the various schemes met in Montreal and formed such an organization to be administered by a commission consisting of a representative from each approved scheme plus the chairman of the Committee on Medical Economics of Canadian Medical Association and administered by an executive of four, elected from the commission," Dr. McCoy reported.

"As a start," he continued, "it was decided that the functions of the organization would be to: 1. Promote the sale of contracts to groups resident in more than one province. 2. Promote inter-plan coordination. 3. Work towards a common contract. 4. Compile statistical returns. It is estimated that 1,200,000 persons are covered at present under these plans and this will now open up potential coverage for a considerably larger number."

Dr. McCoy pointed out that the established provincial plans are well accepted and understood by subscribers and physicians. Each province seems to have its own approach to the matter of welfare coverage, compulsory hospitalization, fee schedules and other problems of medical care.

"We believe," said Dr. McCoy, "that this is a good forward step in setting up Trans-Canada Medical Services. It is hoped it will do for all of Canada what this western conference is doing for western United States and western Canada."



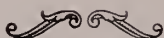


Top row, left to right: Administrators—Mr. Jim Borgen, Bremerton, Wash.; Mr. Willard Marshall, Salem, Ore.; Mr. John Davis, Kennewick, Wash.; Mr. Max Clark, Olympia, Wash., and Dr. L. C. Miller, Wenatchee, Wash.

Center, left to right: State Administrators—Mr. John Steen, Washington; Mr. Joe Harvey, Oregon; Mr. Tom

Dean, Idaho; Mr. Sam English, Montana; Mr. A. L. McLellan and Mr. H. W. Jones, Vancouver, B. C.

Bottom, left to right: Mrs. M. Shelby Jared, Mrs. John Nailor, Mrs. Hal Brown, Mrs. Kirby Torrance, Mrs. Jim Barron and Mrs. George LaFray.



Weston Demands Compulsory Health Insurance via One-Package Plan

Washington State Federation of Labor advocates a compulsory national health insurance program for all wage earners and their dependents, according to Mr. Ed Weston, president of the organization.

"This is simply indicative of our desire that the same relative protection you offer to your subscribers be extended to all," Weston said as he spoke before delegates to the Western Conference of Prepaid Medical Care Plans.

"Today, Labor as an organization is taking a broader interest in medical costs and it is that aspect to which I would like to direct your attention," he said. "From the viewpoint of Labor there must be ever-increasing proof that the costs of medical care, not just for our members, but for all of the population, are being shifted to a pre-paid basis or we inevitably will seek to have minimal programs sponsored by the government. That does not mean socialized medicine for, despite the viewpoint of one professional group, Labor in this country has not endorsed socialized medicine. We have endorsed—speaking of the American Federation of Labor—a program of compulsory national health insurance which would shift the burdensome medical costs to a pre-paid basis, with the broadest possible spread of risk and the resultant low cost to the participating individuals.

"The Pacific Coast, and especially the Pacific Northwest, is the one spot in the nation where a respectable beginning has been made toward comprehensive prepaid medical care programs. You are to be commended for that.

"By this time I hope you are interested in knowing what kind of a plan Labor is interested in and what we don't like about present plans. *First*, the plan should preserve quite free choice of doctors. We have always advocated that and, in passing, our opposition to Medical Aid Contracts under Industrial Insurance or Workmen's Compensation was, and is, based primarily on the limiting factors inherent in Medical Aid Contracts. Now, to us, free choice of doctors has several special meanings. It means that the attending physician should not take refuge in it, but should be ever ready to suggest transfer of the patient to more competent hands. Not all doctors are equally able in all fields. The plan must not restrict the availability of medical talent, and eventually your colleagues in this program of providing medical care are going to have to recognize what we in Labor have known for a long time, namely, that reputable osteopaths and chiropractors do fulfill a needed function in medical care and thus are entitled to greater consideration and more courteous treatment than they now receive. Failure of a pre-paid medical care plan to allow for par-

ticipation by all segments is a limiting factor and results in the recipient becoming more interested in an indemnity program than in a service program.

"*Second*, the plan should do a reasonably good job of insuring on a comprehensive basis. In the immediate future, a goal of 80 per cent of all costs is not unreasonable and there has not as yet been advanced a good reason why *all* the medical costs of the working population and their dependents should not eventually be shifted to a pre-paid basis.

"*Third*, a most important challenge is in the area of broadening your coverage to include more and more of the population, working or not. To do this you must devise ways to offer coverage to rural non-industrial residents. You must continue coverage as people move into the aged groups and into the new retirement programs. In the future a man must be able to *continue* his pre-paid medical care program through periods of lay-off, unemployment, self-employment, new employment and retirement. Your concept of 'group' must be broadened where your entire community is the group and you are able to include individuals without attachment to a qualifying industrial group. I realize that administrative cost problems must be solved before you can do it. You have some cost advantages over the 'indemnity' type of insurance policy even on large groups, and you should use your advantage judiciously to broaden your coverage.

"Probably the most glaring failure of present-day medical practice is in the realm of preventive medical care. The average plan does little and the usual insurance policy does little in the *preventative field*. Who does do it? Charity organizations (cancer and T.B. detection units for example) and the *government agencies*. Who will do it in the future? The government, unless you get there first! Your type of operation does more in the early diagnosis and preventative area than the usual 'indemnity' policy which never pays for the 'ounce of prevention.' Medical care insurance must become more than a financial arrangement. It should become a means of influencing favorably the availability of preventative medicine, early diagnosis, adequate treatment and also the improvement of quantity and quality of medical facilities.

"Now I realize that some of my ideas may make me sound like an advocate of social insurance as contrasted to private insurance in this medical care field. You will note, however, that I have been speaking of goals to be attained, not the means to the end. Frankly, Labor has waited a long time for the medical care industry to make its product available at a price all can afford when they need it."



Journal Officials Hear Ideas on Editing and Management



At a banquet in the Walnut Room, Bismarck Hotel, Chicago, Nov. 12. L. to R.: D. W. Macomber, Editor, Rocky Mountain Medical Journal; Herbert L. Hartley; Wu Paak Shing, Ph.D., Chicago; Mr. A. E. Stensby, Lilly & Co.; George F. Lull, Secretary and General Manager, A.M.A.; Mr. Herbert Dady, Advertising Manager, California Medicine. The banquet followed a cocktail party given in the lounge by Luzier's, Inc.

Three of America's foremost editors accepted the invitation of the American Medical Association to address the editors and business managers of State Medical Journals at the A.M.A. building in Chicago, November 12-13, according to Herbert L. Hartley, editor of *NORTHWEST MEDICINE*, who flew east to attend the nation-wide conference. He was accompanied by Mr. Kirby Torrance, business manager, who attended the three business sessions.

Mr. Walter Kahoe, director, Medical Department, J. B. Lippincott Company, the Monday morning speaker, outlined the way in which advertisers study readership of journals to determine their advertising value.

Mr. Harry L. Shaw, general editor of Harper and Brothers, addressed the Monday afternoon session on the subject, "Language and Thought in Action," and stated that, "writing, when properly managed, is but another name for conversation." He was well received.

Mr. William Allen Richardson, editor, *Medical Economics*, spoke at the Tuesday afternoon session and advised the editors that they did not have adequate staffs and lacked the money necessary to pay for the kind of journals they should have. Then he detailed all the fine things they could accomplish if they had the staffs and the money.

Mr. Alfred Jackson, manager of the State Journal Advertising Bureau, stated that the increase in advertising pages in State Journals for 1951 was 12.7 per cent above 1950. He expected another increase in lineage for 1952.

The conference was the first held in three years and was thoroughly appreciated by the 85 editors and managers present, many of whom took the floor to express their appreciation and urge the A.M.A. to make the conference an annual event.

The Nursepower Shortage

By MARY ELLA ADAMS, R.N.

The serious shortage of nurses is a matter of concern to doctors, hospitals and the general public, as well as to those engaged in nursing. To understand this vital problem, it is necessary to consider some of the causes that have led to the present predicament.

Like many of the problems in our modern world, this one has complex factors. Actually, there are more nurses on the job than ever before in the history of our country. It is not that women have turned from nursing; it is only that not enough have turned to nursing. The shortage exists because the supply has not been able to keep up with the run-away demand.

The urgent need for nursing services mushroomed during World War II and has increased during the uncertain peacetime since the end of the war. Many reasons for this growing demand may be given, chief of which seem to be:

- (1) Urbanization of our population, health education, rising income levels, prepaid health and medical care plans—all of which have resulted in much higher standards of health and medical care for the entire population.

- (2) Advances in medical knowledge which call for more intensive nursing care of patients.

- (3) The military and defense programs which have created unprecedented need for nurses in the various branches of the armed forces.

In Washington State the problem is further complicated by a tremendous influx of people. The population has increased 40 per cent in ten years.

Because of the confusion created in the nursing profession by these expanded demands, the Washington nursing organizations decided to sponsor a survey which would disclose the facts about needs for nursing service in the state and the extent to which the needs were being met.

This survey, *The Washington Nursing Study, 1950*, was conducted under the guidance of a citizens' advisory committee. Dr. Raymond B. Allen, president of the University of Washington, was chairman of the group. The Washington State Medical Association was represented on the committee by its president, Dr. Donald G. Corbett.

According to figures compiled for the study, there exists in the state a total deficit of approximately 2,700 professional nurses and 2,400 non-professional nurses. These figures are based on estimates made in accordance with *desirable standards of nursing service* as well as on actual need.

The largest deficit is in the institutional field where approximately 1,500 more professional nurses and 2,400 more non-professional nurses are needed. Mental hospitals are included in this field. On the basis of care

(Continued on Page 974)

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The Nursepower Shortage

(Continued from Page 972)

recommended as desirable, these institutions are operating with only 9 per cent of the professional nurses and 31 per cent of the non-professional nurses needed to do a satisfactory job.

The survey shows 162 more nurses are required in the public health field to bring the state to a ratio of one nurse to each 5,000 of the population.

The study also attempts to project the problem of nursing needs into the future and to determine how schools of nursing can best meet the demands.

The purposes of the investigation were threefold:

(1) To identify, analyze and discuss existing problems in all areas of nursing service in the State of Washington.

(2) To bring to bear upon the problem of providing good nursing service to people in all parts of the state the combined best thinking of medical, nursing, hospital and lay people and organizations.

(3) To develop a list of principles of nursing education to be used later for recommendations as to the type of schools needed, the number of nurses needed each year, the location and type of programs needed and the determining of sources of financial support.

Out of the 1950 study has come a list of recommendations aimed at alleviating the situation. Several of the present programs of the Washington State Nurses Association are planned toward carrying out the constructive suggestions resulting from the study.

The success of these programs will be determined largely by the extent of cooperation that can be achieved between the hospitals, the nurses and the medical profession. All are aware of the nursepower shortage, and all are vitally concerned. Working together, we can seek a solution.

PASS ALONG YOUR JOURNAL

The monthly mailing list of **NORTHWEST MEDICINE** has passed the 4,500 mark which ranks it among the ten leading state journals of America in point of circulation and prestige. It goes monthly to all doctors who are members of country, state or territorial medical associations in Oregon, Washington, Idaho and Alaska, as well as a considerable number of hospitals, clinics and laboratories.

NORTHWEST MEDICINE will also be sent to non-members of associations for \$5.50 per year or 50 cents per copy.

If you are a regular subscriber to **NORTHWEST MEDICINE** we urge that you pass the journal along to your staff members, technicians or associates. It will be a service to the new readers and of benefit to our advertisers, approximately 70 of whom carry regular schedules of advertising in **NORTHWEST MEDICINE**.



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CORRESPONDENCE

October 15, 1951

To the Editor:

At a recent meeting of North-Pacific Society of Internal Medicine I was appointed a committee of one to ask about the possibility of enlarging the scope of excellent work you are already doing in your department of Meetings of Medical Societies. I am sure that other organizations also find this a boon as a reference calendar in planning dates and places for meetings which have to be planned many months or a year in advance, using this department as a reference calendar for possible conflicts.

In the past we have occasionally run into minor conflicts unwittingly with meeting dates corresponding to those of other medical organizations.

Our members wondered if it would be possible for NORTHWEST MEDICINE to keep an even more elaborate calendar of future meeting dates of various organizations. For example, North-Pacific Society of Internal Medicine would like to have a ready reference source for exact meeting dates of such organizations as American College of Physicians, both their national and their western sectional meetings, as well as of the several Refresher Courses offered by University of Oregon Medical School and University of Washington School of Medicine.

I suppose it represents a problem to your office to secure from the various secretaries of these organizations the times and places of their meetings. At any

rate, our own society will continue to refer to your published department in trying to select times for our own meetings and we may try calling you from time to time or writing you about possible meeting dates of other organizations that are not regularly published.

Very sincerely yours,

C. R. JENSEN

Seattle

This has been a surprisingly difficult problem. We are far from satisfied with our record in this department but find it almost impossible to obtain all desired information. We have seriously considered eliminating it entirely unless it can be done more satisfactorily. With this encouragement from an important society, we shall keep trying. Other secretaries please note.

November 7, 1951

To the Editor:

The article entitled *Local Anesthesia in Gynecologic Surgery* by Harold E. Dedman, M.D., which appeared in the October, 1951, issue of NORTHWEST MEDICINE referred to the Abbott product, Nembutal, as a common name.

We fully realize the difficult problem a proofreader faces in watching the many trade-mark names. However, as you know, descriptive or common use of a

(Continued on Page 978)

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SURGERY—Intensive Course in Surgical Technic, two weeks, starting January 21, February 4, February 18. Surgical Technic, Surgical Anatomy & Clinical Surgery, four weeks, starting March 3, June 2. Surgical Anatomy & Clinical Surgery, two weeks, starting March 17, June 16. Surgery of Colon & Rectum, one week, starting March 3, April 7. Gallbladder Surgery, ten hours, starting April 21. Basic Principles in General Surgery, two weeks, starting December 10, March 31. Breast & Thyroid Surgery, one week, starting June 23. Esophageal Surgery, one week, starting June 23. Thoracic Surgery, one week, starting June 2.

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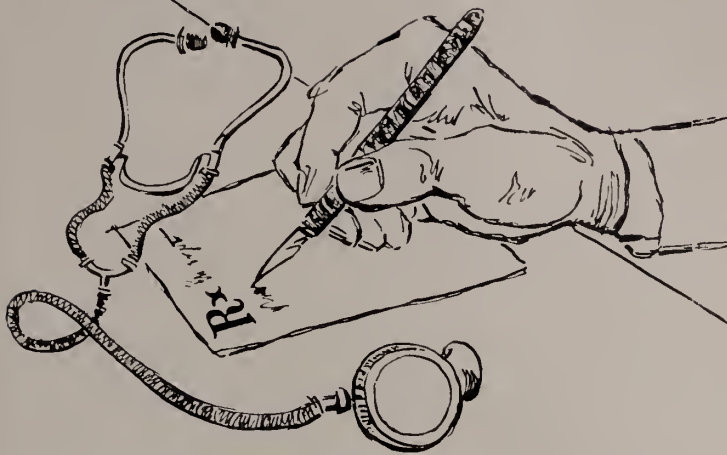


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(Continued from Page 976)

trade-mark tends to weaken its exclusive ownership. For example, that is what happened to the once valuable trade-marks *escalator* and *aspirin*.

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Sincerely yours,

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L. F. REED, *Patent Counsel*

We apologize. This was the editor's error and he is glad to have the oversight called to his attention.

704 American Building,
November 1, 1951

To the Editor:

Crusade for Freedom headquarters for Washington and Alaska are here; for Oregon it is 230 Lumbermen's Bldg., Portland, Ore. I do not have the address of headquarters in Idaho, but you may tell your readers that contributions may be sent, in any city, to Crusade for Freedom, % Postmaster.

Dr. R. A. Benson, president of the Washington State Medical Association, is a member of our State Sponsors Committee. Dr. Benson, in accepting the appointment, said: "Being in full accord with the ideals and principles which your organization is promulgating I would consider it a pleasure to have my name included."

In a subsequent letter, Dr. Benson said: "It is indeed gratifying to know that the campaign for the Crusade for Freedom is moving forward in our State of Washington and I feel confident that there will be a general and widespread support as soon as the aims and purposes of this organization are made known. To me this represents the opportunity of spreading the gospel of democratic freedom through word and deed in the belief that the strength of conviction is as great as the strength of arms.

"I shall be glad to aid in this Crusade by whatever means I can. I am in hopes that shortly, with the help of your office, I can aid in alerting, as well as interesting, our profession in this cause."

If there is any further information you desire, please feel free to call upon us at any time.

HERBERT E. VEDDER, *Executive Director*
Crusade for Freedom, Seattle

Caldwell, Idaho
November 6, 1951

To the Editor:

I have been reading a recent monograph by Youmans and Huckins entitled *Hemodynamics in Failure of the Circulation*, which amounts to an excellent review of basic physiological principles pertaining to heart function.

It occurred to me that those of us who are busy general practitioners (or specialists, for that matter) could profit from occasional exposure to a *brief but lucid* review of basic science subjects. Now that we have two medical schools in our area, perhaps a member of a department in one or the other could be induced to prepare such a piece for publication in *NORTHWEST MEDICINE*. I personally feel it would enhance the usefulness of the publications.

Yours very truly,

D. R. PETERSON

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References:

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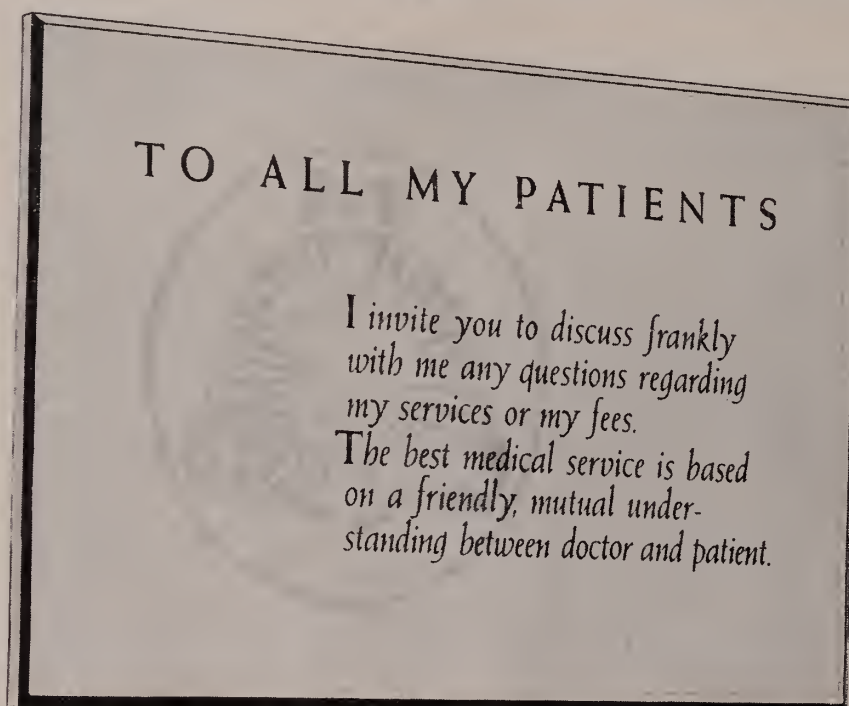
PROTEIN	10.5 Gm.	IRON	4 mg.	NIACIN	2.3 mg.
FAT	10.5 Gm.	COPPER	0.2 mg.	VITAMIN C	10 mg.
CARBOHYDRATE	22 Gm.	VITAMIN A	1000 I.U.	VITAMIN D	140 I.U.
CALCIUM	370 mg.	VITAMIN B ₁	0.39 mg.	CALORIES	225
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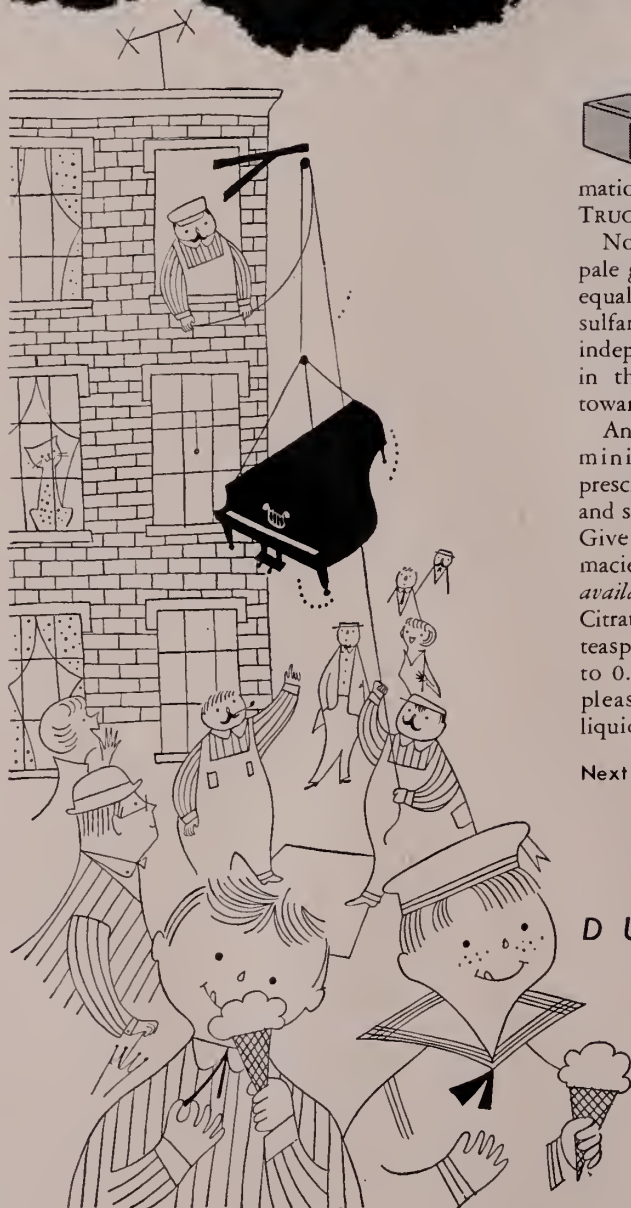
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NORM

Normal schedule of development (auxodrome) plotted on Wetzel Grid.¹

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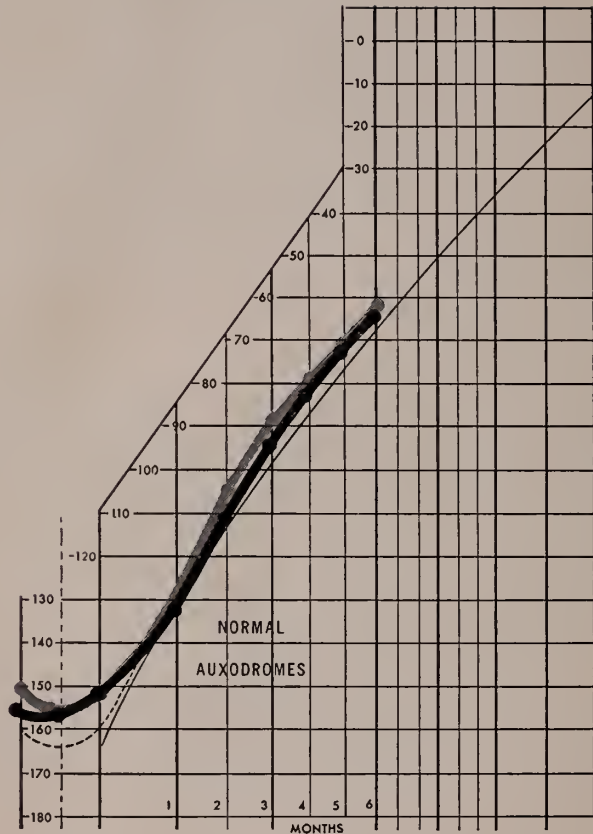
Composite Wetzel Grid auxodrome of 60 unselected infants on S-M-A from birth to 6 months of age.

CURVE B

Growth data, recomputed on Wetzel Grid, based on "selected subjects, most of whom were favored by environment;"² age: from birth to 6 months.

1. Wetzel, N. C.:
J. Pediat. 29:439,
1946.

2. Jackson, R. L.,
and Kelly, H. G.:
J. Pediat. 27:215,
1945.



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*Gosselin, George A., M.D.
Neurology and Physiology in Functional States
Connecticut State Medical Journal
 15: 109-113, (February) 1951

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Gray, L.: J. Clin. Endocrinol. 3:92 (Feb.) 1943.

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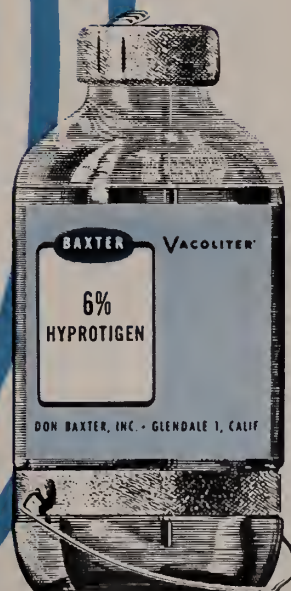


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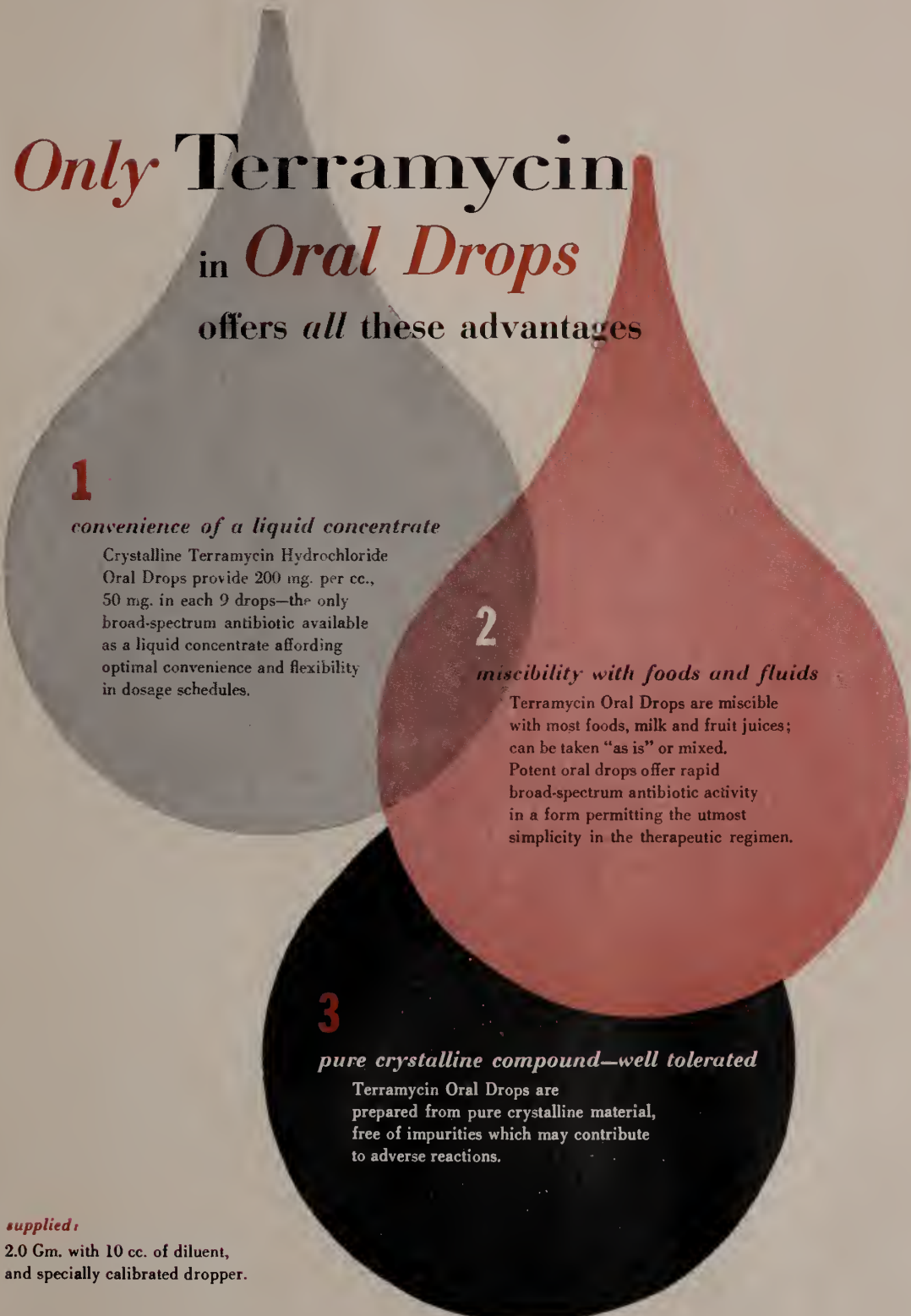
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- Oregon State Medical Society.....Portland
President, Blair Holcomb Secretary, R. F. Miller
Portland Portland
- Tacoma Surgical Club.....Annual Meeting, May 3, 1952
Secretary, A. A. Sames
Tacoma
- Washington State Medical Association.....Sept. 13-17, 1952
President R. A. Benson Secretary, Bruce Zimmerman
Bremerton Seattle
- Idaho State Medical Association.....Sun Valley—June 15-18, 1952
A. M. Popma Secretary, R. S. McKean
Boise Boise
- Alaska Territorial Medical Association.....McKinley Park—June, 1952
President, H. Romig Secretary, W. P. Blanton
Anchorage Juneau

PERIODICAL SOCIETY MEETINGS

NORTHWEST

- North Pacific Society of Neurology and Psychiatry.....Seattle, 1952
President, S. N. Berens Secretary, R. A. Coen
Seattle Portland
- North Pacific Pediatric Society.....Portland, March, 1952
President, Carl Ashley Secretary, S. G. Babson
Portland Portland
- North Pacific Surgical Assn.....Vancouver, B. C., Nov. 16-17, 1951
President, S. F. Herrmann Secretary, J. A. Duncan
Tacoma Seattle
- North Pacific Society of Internal Medicine.....Sun Valley, Idaho
Sept. 19-20, 1952
President, C. R. Jensen Secretary, R. L. King
Seattle Seattle

OREGON

- Central Willamette Society.....Second Thursday
President, W. W. Ball Secretary, F. R. Asbury
Corvallis Corvallis
- Oregon Academy of Ophthalmology and Otolaryngology—Third
Tuesday, Old Heathman Hotel, Portland
President, R. S. Fixott Secretary, G. E. Chamberlain
Portland Portland
- Oregon Pathologists Association, Second Wednesday—Portland
President, V. D. Sneed Secretary, J. E. Nohlgren
Portland Portland
- Oregon Radiological Society—Second Wednesday—University
Club, Portland
President, Arthur Hunter Secretary, J. R. Raines
Portland Portland
- Portland Academy of Pediatrics.....First Monday
President, S. G. Babson Secretary, Edward Rector
Portland Portland
- Portland Surgical Society.....Last Tuesday
President, J. M. Roberts Secretary, J. W. Nadal
Portland Portland
- Southern Oregon Medical Society.....Roseburg—May 13, 1952
President, A. M. Johnson Secretary, F. C. Adams
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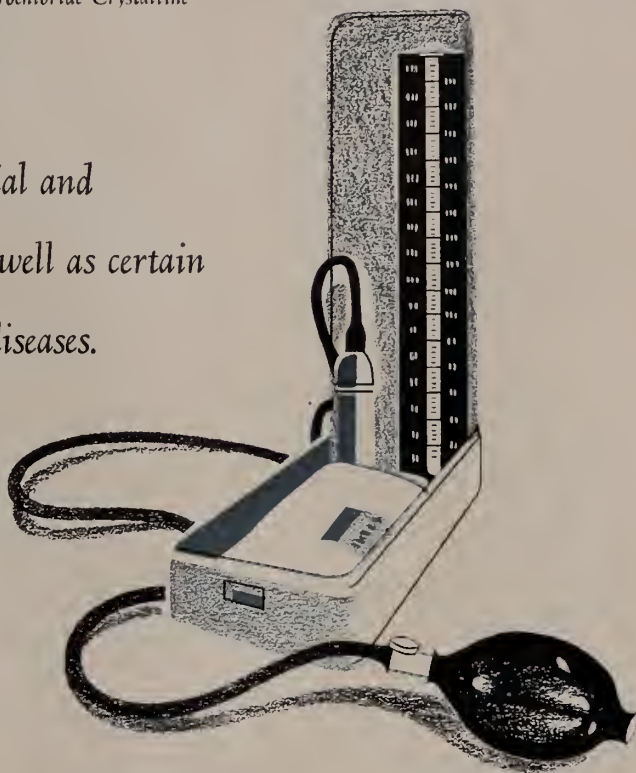
WASHINGTON

- Washington State Obstetrical Society.....Vancouver, B. C.
May 3, 1952
President, E. G. Layton Secretary, L. B. Donaldson
Seattle Seattle
- Puget Sound Academy of Ophthalmology and Otolaryngology
.....Third Tuesday—Seattle or Tacoma
President, J. F. Tolan Secretary, Willard Goff
Seattle Seattle
- Seattle Academy of Surgery.....Third Friday
President, D. O. Kraabel Secretary, H. L. Schiess
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- Seattle Gynecological Society.....Third Wednesday
President, Gerald Thomas Secretary, Hugh Nuckols
Seattle Seattle
- Seattle Pediatric Society.....Fourth Friday
President, W. A. Jaquette Secretary, G. E. M. Adkins
Seattle Seattle
- Seattle Psychoanalytic Study Group.....First Thursday
President, Gert Heilbrunn Secretary, E. W. Haertig
Seattle Seattle
- Seattle Surgical Society.....Annual Meeting, Feb. 8-9, Seattle
President, J. A. Duncan Secretary, R. B. Hearne
Seattle Seattle
- Washington State Society of Anesthesiologists.....Fourth Friday
President, D. C. Moore Secretary, K. F. Eather
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References:

1. Stokes, J., Maris, E. P., and Gellis, S. S., *The Use of Concentrated Normal Human Serum Globulin (Human Immune Serum Globulin) in the Prophylaxis and Treatment of Measles*, *J. Clin. Invest.*, 23:531-540, 1944.
2. Karelitz, S., *Dose Modified Measles Result in Lasting Immunity?*, *Jour. Pediat.*, 36:697, June 1950.
3. Stokes, J., *Use of Gamma Globulin from Large Pools of Adult Blood Plasma in Certain Infectious Diseases*, *Ann. Int. Med.*, 26:453, 1947.



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